

TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

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VR A15ME
SM 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04866 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04865

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) e. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kent Village	
c. LENGTH OF STAY IN lb D.O.A.		d. STREET ADDRESS 2807 Forest Terrace	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Monica Rose Alder		4. DATE OF DEATH Month Day Year April 20, 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 14, 1960	
9. AGE (in years last birthday) 1		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willard Lee Alder Jr.		14. MOTHER'S MAIDEN NAME Barbara Ann Van Pelt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Willard Lee Alder Jr.		Address smae as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failgrs 744.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Myasthenia gravis (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> el work Not While <input type="checkbox"/> el work	
20e. PLACE OF INJURY (Home, farm, lectory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/20/62		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/62	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or country) (State) Washington D. C.	
23. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE APR 24 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04867

04866

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Westmoreland Co.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forestville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ligonier					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3337--Senator Ave. S.E.				d. STREET ADDRESS Star Rt # 711 South					
3. NAME OF DECEASED (Type or print) First LILLIAN Middle MAY Last APPEL				4. DATE OF DEATH Month April Day 12 Year 1962					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 18, 1883			
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Harry Albright				14. MOTHER'S MAIDEN NAME Mathilda Graft	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address Mrs. Alice Lammert 3337-Senator Ave. S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 4-20-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day 15 yrs									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-5 19 62 to 4-12 19 62 that (I) (we) last saw the deceased alive on 4-10 19 62 and that death occurred at 1P M, from the causes and on the date stated above.									
22a. SIGNATURE Thomas F. Cleary				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas F. Cleary M.D.				22d. ADDRESS 5558 S. Lee H. H. Rd. District Heights, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF April 16 -62		23c. NAME OF CEMETERY OR CREMATORY Alleghany Co. Memorial Park		23d. LOCATION (City, town, or county) (State) Pittsburgh, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Summers Brother				ADDRESS 1661- Good Hope Road SE. Washington 20, D.C.				25a. REC'D BY REGISTRAR DATE APR 16 '62	
								25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

11. Name of informant: [illegible]
12. Address of informant: [illegible]
13. Signature of informant: [illegible]
14. Date of completion: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04868 04867											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kennelworth				c. LENGTH OF STAY IN 1b 12 yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 43 Kennelworth				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1607 Eastern Avenue						d. STREET ADDRESS 1607 Eastern Avenue					
3. NAME OF DECEASED (Type or print) Alexious A. Baker						4. DATE OF DEATH April 9 19 62					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 18, 1886		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Navy Yard		11. BIRTHPLACE (State or foreign country) District of Columbia				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Fannie Prosperi					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.I						16. SOCIAL SECURITY NO. None					
17. INFORMANT Mrs. Grace Webb Bulloch, 3009 -37th.St.,						Address Washington, D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422 Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Myocardial insufficiency (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) James I. Boyd						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/11/62		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery				22d. LOCATION (City, town, or country) (State) Washington, D.C.	
23. FUNERAL DIRECTOR W.W. Chambers Co.						24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur L. H...					
Riverdale, Maryland						DATE APR 17 '62					

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James I. Boyd, 18 yrs, 1907 Eastern Avenue, Baltimore, Md.

James I. Boyd, 18 yrs, 1907 Eastern Avenue, Baltimore, Md.

James I. Boyd, 18 yrs, 1907 Eastern Avenue, Baltimore, Md.

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James I. Boyd, 18 yrs, 1907 Eastern Avenue, Baltimore, Md.

James I. Boyd, 18 yrs, 1907 Eastern Avenue, Baltimore, Md.

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FOR STATE HEALTH DEPT. M

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04869

04868

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN TB D.O.A.		d. STREET ADDRESS 3402 54th. Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Moncure Barlow		4. DATE OF DEATH April 16, 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 11, 1920	
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Moncure Barlow		14. MOTHER'S MAIDEN NAME Romero	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 230-03-6950	
17. INFORMANT Helen Martha Barlow		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute occlusion of Coronary Artery 420.1 Conditions, if any, which gave rise to immediate cause (b) HEMORRHAGE IN ATHEROMATOUS PLAQUE (c) HEMORRHAGE IN ATHEROMATOUS PLAQUE caused the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEMORRHAGE IN ATHEROMATOUS PLAQUE			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/19/62	
22c. NAME OF CEMETERY OR CREMATORY Arlington Mt. Washington Co.		22d. LOCATION (City, town, or country) (State) Arlington, Va.	
23. FUNERAL DIRECTOR W.W. Chambers Co. Washington, D.C.		24a. REC'D BY REGISTRAR APR 18 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Krane		DATE	

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Prince George's

Maryland

Prince George's

Havettville

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Overly

7-02 5th, Avenue

Prince George's General Hospital

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April 19

Barlow

Monroe

Charles

Dec. 11, 1950

Male White

U.S.A.

Virginia

U.S. Army

S.P. 2

Tomoro

Charles Monroe Barlow

Yes 1947 - 1952 07-03-0501 Walter Martin Barlow Same as 42

Birth certificate and General Agency
Reference in Baltimore, Maryland

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x

x

x

4/26/68

x

James J. Boyd, M.D.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Items 18 & 21, Film G-512 5/7/62.cac.											
1. PLACE OF DEATH a. COUNTY		Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE		Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Cheverly		D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		24 Suitland		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Prince George's General Hospital				d. STREET ADDRESS		4489 Brooks Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		Charles		Henry		Barth		4. DATE OF DEATH		April 28, 1962	
5. SEX		Male		6. COLOR OR RACE		White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
										Feb. 15, 1917	
										9. AGE (in years last birthday)	
										45 yrs.	
										IF UNDER 1 YEAR	
										Months Days	
										Hours Min.	
										IF UNDER 24 HRS.	
										Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Assistance Manager Peoples Drug		10b. KIND OF BUSINESS OR INDUSTRY		New Jersey		11. BIRTHPLACE (State or foreign country)		U.S.A.	
13. FATHER'S NAME		Charles		Barth		Lillian Walters		14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		Yes		W.W. 11		136-05-3363		Jean Hess Barth		Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		(PENDING)		Acute hemorrhagic necrosis of gastro intestinal tract.		INTERVAL BETWEEN ONSET AND DEATH			
		971.3		DUE TO		Ingestion of ammonium hydroxide					
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO							
				(b)							
				(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Grand Mal Epilepsy								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Unnatural death <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE		Paul Van Natta		M.D.		DEPUTY MEDICAL EXAMINER		DATE SIGNED		4/28/62	
EXAMINER'S NAME (Type)		Paul Van Natta, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		May 2, 1962		22c. NAME OF CEMETERY OR CREMATORY		Arlington Nat'l. Cemetery Arlington, Virginia	
23. FUNERAL DIRECTOR		1661--Good Hope Rd., SE		ADDRESS		Washington 20, DC		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE		MAY 1 '62									

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(M)

(Pawnee)

Slawson 103

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04871

04870

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince Georges County			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 15 Min.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt		d. STREET ADDRESS 23C Parkway	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ralph A. Bartholomew				4. DATE OF DEATH Month Day Year April 25, 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-12	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Specialist		10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Theodore R Bartholomew				14. MOTHER'S MAIDEN NAME Anna E Dross			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Doris L. Bartholomew Greenbelt, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bilateral Pulmonary congestion DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Cardiac Failure CORONARY THROMBOSIS 40-12 yrs. 6 wks						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 25, 1962, to April 25, 1962 that (I) (we) last saw the deceased alive on April 25, 62 and that death occurred at 9:45 P.M. the causes and on the date stated above.							
22a. SIGNATURE Albert Roth M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Albert Roth				22d. ADDRESS 5510 Madison St., Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		23b. DATE THEREOF 4/26/62		23c. NAME OF CEMETERY OR CREMATORY Centerville		23d. LOCATION (City, town or county) (State) Iowa	
24 FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE APR 30 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hawk	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01820

CERTIFICATE OF DEATH

1930

(M)

State of Tennessee, County of Davidson, City of Nashville, State of Tennessee.

That I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 1st day of April, 1930, at Nashville, Tennessee, I attended the last illness of

John I. Davidson, deceased, who died at the residence of the deceased, at Nashville, Tennessee, at the age of 62 years.

The cause of death was: Myocardial infarction, due to athero-sclerosis of the coronary arteries.

The death was sudden and unexpected, and there was no violence or other external cause.

The body was found in the bed, and the death was due to natural causes.

The death was not due to any contagious or infectious disease, and no other person was exposed to the disease.

The death was not due to any mental or nervous disease, and no other person was exposed to the disease.

The death was not due to any other cause, and no other person was exposed to the disease.

The death was not due to any other cause, and no other person was exposed to the disease.

The death was not due to any other cause, and no other person was exposed to the disease.

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The death was not due to any other cause, and no other person was exposed to the disease.

The death was not due to any other cause, and no other person was exposed to the disease.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, or any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VR A15ME
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04872 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04871

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights	
c. LENGTH OF STAY IN b. D.O.A.		d. STREET ADDRESS 8 Delano Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William John Bartz Sr.		4. DATE OF DEATH April 8th., 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1912	
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tile setter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Frederick Bartz		14. MOTHER'S MAIDEN NAME Catherine Sagorski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-18-7052	
17. INFORMANT Irene Ethel Bartz, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/8/62	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 11-62	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or country) (State) Bladensburg MD	
23. FUNERAL DIRECTOR Simmons Bros. 1661- Good Hope Rd SE WASH 20 DC		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
DATE APR 11 '62		Signature	

(M)

61873

04871

Director of the Bureau of the Census

Washington, D. C.

Dear Sir:

I am writing to you regarding the matter of the

report of the Committee on the

Report of the Committee on the

Report of the Committee on the

Report of the Committee on the

Report of the Committee on the

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04873

CERTIFICATE OF DEATH

04872

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 6703 Redfield Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dorothy I. Beaver		4. DATE OF DEATH Month Day Year April 30 1962					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-83	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Washington D C		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Claude Marion		14. MOTHER'S MAIDEN NAME Marinda Reynolds					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records Cheverly Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332 X IMMEDIATE CAUSE (a) Necrosis of left cerebellar hemisphere DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 week years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-23 , 19 62 to 4-30 , 19 62 that (I) (we) last saw the deceased alive on 4-30 , 19 62 , and that death occurred 9:40 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Hei K. Lee M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> A.M.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Hei Kit Lee				22d. ADDRESS 7730 Annapolis Road, Lanham, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1962		23c. NAME OF CEMETERY OR CHURCH U S Soldiers Home Cemetery		23d. LOCATION (City, town or county) (State) Washington D C	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md.				25a. REC'D BY REGISTRAR DATE MAY 4 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

(M)

(I)

Prince George's

Chesley

1 day

Prince George's General Hospital

6705 Redfield Avenue

Hyattsville

Maryland

Prince George's

Female

White

Borothy

1.

Beaver

April 30

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Washington D.C.

Johns Hopkins

Ward - 1010

Prince George's

General Hospital, Chesley, Md.

History of Fall from Ladder

1 year

General Hospital

Johns

1-1-53

62

1-1-53

62

1-1-53

A.M.

Dr. J. E. Lee

May 1, 1953 - 1000 - 1000 - 1000

Prince George's General Hospital, Hyattsville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04874 CERTIFICATE OF DEATH 04873

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 27 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) W. Hyattsville d. STREET ADDRESS 6100 Ager Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Eugene Middle E. Last Behrend				4. DATE OF DEATH Month April Day 26 Year 19 62											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-7-78		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Mfgd. jewelry				11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Uriha Behrend						14. MOTHER'S MAIDEN NAME Frances Etting									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 579-54-7889		17. INFORMANT J. Norman Ager - 6100 Ager Rd., W. Hyattsville, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pyelonephritis with Uremia 540 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Perforated gastric ulcer, post-surgical status DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 27 days															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 3/30/62 to 4/26/62 , that (I) (we) last saw the deceased alive on 4/26/62 , and that death occurred at 11:00 from the causes and on the date stated above.															
22a. SIGNATURE David S. Clayman M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE 4/26/62					
22c. PHYSICIAN'S NAME (Type) Dr. David S. Clayman						22d. ADDRESS 6311 Baltimore Ave., Riverdale, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-30-62		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City, town or county) (State) Washington, D.C.					
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska Warner E. Pumphrey, Inc., Silver Spring, Maryland						25a. REC'D BY REGISTRAR APR 30 '62				25b. REGISTRAR'S SIGNATURE Arthur L. Hines					

04873

STATE OF TEXAS

04873

(M)

George's

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04875

CERTIFICATE OF DEATH

04874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. LENGTH OF STAY IN 1b 10 years.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6313-LIVINGSTON Rd. S.E.		d. STREET ADDRESS 6313-LIVINGSTON Road.	
3. NAME OF DECEASED (Type or print) BENJAMIN BRISCOE BELL		4. DATE OF DEATH Month APRIL Day 2 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY. 1. 1893
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL (MD)	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME CHARLES DAVID BELL		14. MOTHER'S MAIDEN NAME Clara W. STEPHENS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. 579-03-2825	
17. INFORMANT Address Clarence M. BELL (brother) WARSAW, VA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA of LUNGS. 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 19 62 , to APRIL 19 62 , that I last saw the deceased alive on MARCH 31 , 19 62 , and that death occurred at 7:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Max E Feldman M.D.		ADDRESS (Street, city or town, state) 3800 E. Capitol St. Wash. 20 D.C.	
PHYSICIAN'S NAME (Type) MAX E. FELDMAN M.D.		DATE SIGNED 4/2/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried April 4-62		22b. DATE THEREOF Buried by church	
22c. NAME OF CEMETERY OR CREMATORY WARSAW, VA.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		ADDRESS 1661-g Hope Rd	
24a. REC'D BY REGISTRAR APR 5 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED: JOHN J. BROWN

2. SEX: MALE

3. AGE: 65

4. DATE OF BIRTH: 1890

5. PLACE OF BIRTH: NEW YORK

6. OCCUPATION: LABORER

7. CAUSE OF DEATH: HEART DISEASE

8. PLACE OF DEATH: HOME

9. DATE OF DEATH: 1955

10. SIGNATURE OF PHYSICIAN: [Signature]

11. SIGNATURE OF REGISTRAR: [Signature]

12. COUNTY OF DEATH: BALTIMORE

13. CITY OF DEATH: BALTIMORE

14. STATE OF DEATH: MARYLAND

15. COUNTY OF RESIDENCE: BALTIMORE

16. CITY OF RESIDENCE: BALTIMORE

17. STATE OF RESIDENCE: MARYLAND

18. COUNTY OF BIRTH: BALTIMORE

19. CITY OF BIRTH: BALTIMORE

20. STATE OF BIRTH: MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04876

CERTIFICATE OF DEATH

04875

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MD. Washington, D. C. b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Catherine Bellavin		4. DATE OF DEATH Month Day Year April 26 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-82
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. B. PLACE (County & State, or foreign country) Russ. Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ignatius Lubo		14. MOTHER'S MAIDEN NAME Anna ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nicholas P. Bellavin		Address Same as # 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 153.3 DUE TO Multiple perforations of descending colon Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) Intestinal Obstruction DUE TO (c) Carcinoma of the Sigmoid Colon		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/18, 1962 to 4/26, 1962 that (I) (we) last saw the deceased alive on 4/26, 1962, and that death occurred 11:05, from the causes and on the date stated above.			
22a. SIGNATURE Hei K. Lee M.D.		22b. DATE SIGNED A.M.	
22c. PHYSICIAN'S NAME (Type) Dr. Hei Kit Lee		22d. ADDRESS 7730 Annapolis Rd., Lanham, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 1 - 62	23c. NAME OF CEMETERY OR CREMATORY Washington National	23d. LOCATION (City, town or county) (State) Suitland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Summers Bros		25a. REC'D BY REGISTRAR APR 30 '62	
ADDRESS 1666 Good Hope Rd.		25b. REGISTRAR'S SIGNATURE William L. Thomas	

Prince George's

General

8 days

Outland, Maryland

History

4000 (approx) 8.2. (approx)

Prince George's General Hospital

Georgetown

Bellevue

April 22

Prince George's

10-10-82

10-10-82

Domestic

Health Bureau

USA

Georgetown info

Anna

Nicholas I. Belavyn Sum no 2.2.

Generalized peritonitis
Intensive management of peritonitis
Intensive management of peritonitis
Intensive management of peritonitis

40

4:30

82

4:15

82

4:30

Dr. Belavyn - 82, 10-10-82

Dr. Belavyn - 82, 10-10-82

TO HOWARD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
#

04877

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04876

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Francis B.F. Benton		4. DATE OF DEATH Month Day Year April 17 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1913
9. AGE (In years lost birthday) 49 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Benton		14. MOTHER'S MAIDEN NAME Anna Lipska	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. 505 1016 76	
17. INFORMANT Wife		Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/16 19 62 to 4/17 19 62 , that (I) (we) last saw the deceased alive on 4/16 19 62 , and that death occurred at 6:45 A.M. the causes and on the date stated above.			
22a. SIGNATURE Max M. Herzberg		22b. DATE SIGNED April 17, '62	
22c. PHYSICIAN'S NAME (Type) Dr. M. Herzberg		22d. ADDRESS 7016 Greig St., Seat Pleasant, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/20/1962	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmarmanor Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J.W. - Lees Wash. D.C.		25a. REC'D BY REGISTRAR DATE APR 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1937

CERTIFICATE OF DEATH

1937

(M)

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
AGE
SEX
MARRIAGE
OCCUPATION
EDUCATION
RELIGION
BIRTH
DEATH
BURIAL

1. Name of deceased
2. Date of death
3. Place of death
4. Cause of death
5. Age
6. Sex
7. Marriage
8. Occupation
9. Education
10. Religion
11. Birth
12. Death
13. Burial

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04878

04877

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lanham				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 67 Lanham			
c. LENGTH OF STAY IN lb 23 months				d. STREET ADDRESS 347 Cipriano Road			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 347 Cipriano Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Paul Middle Eugene Last Berger				4. DATE OF DEATH Month April Day 1 Year 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 28, 1899 62	
9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver				10b. KIND OF BUSINESS OR INDUSTRY Transportation West Virginia			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown Robert Berger				14. MOTHER'S MAIDEN NAME Unknown - Lola Frye			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW 1				16. SOCIAL SECURITY NO. 578 24 4278 Virginia Davis Berger, same as # 2			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary arteriosclerotic heart disease (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 4/1/62			
				Address (Street, city, town, or county) (State)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/62		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		22d. LOCATION (City, town, or country) (State) Bladensburg Maryland	
23. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Md.				24a. REC'D BY REGISTRAR APR 3 '62			
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

104273

00973

(M)

(1)

[Handwritten signature]

Shenandoah Co. Shenandoah, Va.

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

YR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04879 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04878

1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Capitol Heights				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 27 Capitol Heights			
c. LENGTH OF STAY IN 1b 40 yrs.				d. STREET ADDRESS 420 - 57th. Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 420 - 57th. Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George Washington Blake		4. DATE OF DEATH April 23, 19 62		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 27, 1897 65 yrs.		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Blake		14. MOTHER'S MAIDEN NAME Ida Elizabeth Lovejoy		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 220-03-4075		17. INFORMANT Mrs. Dora Barnett; Capitol Hgts. Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH Sudden			
4201 DUE TO (b) Coronary Disease (Arteriosclerosis)				unknown			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) General Arteriosclerosis				unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchial Asthma (Emphysema)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) natural Causes					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Paul R Van Natta		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 23, 1962	
EXAMINER'S NAME (Type) Dr. Paul C. VanNatta		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Suitland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27-1962		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or country) (State) Suitland, Md.	
23. FUNERAL DIRECTOR W. W. Chambers Co - Riverdale, Md.		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur L. Hines		DATE APR 30 '62	

MEDICAL CERTIFICATION

• 3'ry. 04

1965, 1966, 1967

Figure 1. Schematic representation of the experimental design.

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04880 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04879

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 29 Seat Pleasant		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 1 7410 F Street, N.E.		
3. NAME OF DECEASED (Type or print) First Middle Last Doris Evelyn Blankenship			4. DATE OF DEATH Month Day Year April 5th, 1962		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1954		9. AGE (in years last birthday) 8 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Blankenship		14. MOTHER'S MAIDEN NAME Pauline Virginia Abbott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Pauline V. Abbott, 7410 F St., N.E., Seat Pleasant, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812X DUE TO CONTUSIONS OF BRAIN Conditions, if any, which gave rise to immediate cause (b) } DUE TO (a), stating the underlying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> BILATERAL PNEUMONIA					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Skating in the street when stuck by automobile			
20c. TIME OF INJURY Month, Day, Year Hour Minute 5:15 p.m. 3/24 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.) Street	
20f. (City or town) Carmondy Hills, P.G., Md.		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		JAMES I. BOYD, M.D.		DATE SIGNED 4/5/62	
EXAMINER'S NAME (Type)		JAMES I. BOYD, M.D.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, OR OTHER DISPOSITION <input checked="" type="checkbox"/> (Specify)		22b. DATE THEREOF April 10, 1962		22c. NAME OF CEMETERY Mud Fork Cemetery	
22d. LOCATION (City, town, or country) (State)		Mud Fork, Logan Cty. W. Va.			
23. FUNERAL DIRECTOR ADDRESS		W. W. CHAMBERS CO., Riverdale, Maryland		24a. REC'D BY REGISTRAR APR 11 '62	
24b. REGISTRAR'S SIGNATURE		Arthur S. [Signature]			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1

Prince George's

Maryland Prince George's

Geography

Geography

Prince George's General Hospital

1410 E. Street, N.E.

Doris Evelyn

Relationship

April 5th, 1958

Female White

Jan. 2, 1958

Orin

Washington, D. C.

Thomas Relationship

Pauline Virginia Abbott

None

None

None

Pauline V. Abbott, 1410 E. St., N.E.,
Washington, D.C.

Relationship of Person

Relationship of Person

Examine in the office when struck by automobile

Garmony Hill, P.O., Md.

X Street

2:15 PM

X

James I. Reid

JAMES I. REID, M.D.

April 12, 1958, 1410 E. Street, N.E., Washington, D.C.

W. CHAMBERS CO., RIVERSIDE, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04881

04880

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>30 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>65 Riverdale</u>		d. STREET ADDRESS <u>4708 Oslethorpe St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Keland Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W</u> Last <u>Boland</u>				4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-31-'80</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-U.S. Govt.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Edward Boland</u>				14. MOTHER'S MAIDEN NAME <u>Phoebe Jennie Paxton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Spanish - Amer.</u>				16. SOCIAL SECURITY NO. <u>Hospital Record</u>			
17. INFORMANT <u>Hospital Record</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Badger's disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-9</u> , 19 <u>62</u> , to <u>4-9</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>4-9</u> , 19 <u>62</u> , and that death occurred at <u>4:25</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>D.R. Purdie</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/13/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>				ADDRESS <u>Hyattsville, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 12 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>			



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FOR STATE
HEALTH DEPT. (M)
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, the delay should be noted in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04882 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04881

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly D.O.A.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 74 Beltsville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George Gen.				d. STREET ADDRESS 12424 Old Gun Power Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Regina Marie Bowen		4. DATE OF DEATH April 22 1962		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 10, 1962		9. AGE (In years last birthday) 2		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Montgomery Co. Md.		12. CITIZEN OF WHAT COUNTRY? yes USA	
13. FATHER'S NAME Charles L. Bowen		14. MOTHER'S MAIDEN NAME Ester Marie Davis		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles L. Bowen - Same as #2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hours		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year 19			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion, death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul C. Van Natta				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul C. Van Natta				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)				DATE SIGNED 4/22/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/62		22c. NAME OF CEMETERY OR CREMATORY Derwood Cemetery		22d. LOCATION (City, town, or country) (State) Derwood, Maryland	
23. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE APR 26 '62			

2-052223

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04883											
04882											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Md. b. COUNTY Prince George's							
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY in 1b 2 days				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 70 Berwyn, Hgts, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 9112 Baltimore Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MECK Middle ELIZA Last Boyle				4. DATE OF DEATH April 28 1962							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 16, 1882 79 yrs.		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) VIRGINIA			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME HENRY FITZHUGH				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. UNKNOWN				17. INFORMANT Hosp. Record Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 286.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure (c) Malnutrition and dehydration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) INTERVAL BETWEEN ONSET AND DEATH 2 days ? 1 month ? 1 month 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21. I certify that (I) (this hospital) attended the deceased from 4-26 to 4-28, 1962 that (I) (we) last saw the deceased alive on 4-28, 1962, and that death occurred at 6:30 PM, from the causes and on the date stated above.											
22a. SIGNATURE Ronald E Krum M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 4-28-62			
22c. PHYSICIAN'S NAME (Type) RONALD E KRUM				22d. ADDRESS LELAND MEM HOSPITAL, RIVERDALE, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-1-1962		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.				23d. LOCATION (City, town or county) (State) Bladensburg, Maryland.			
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.; Riverdale, Md.				ADDRESS				25a. REC'D BY REGISTRAR DATE MAY 2 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04884

CERTIFICATE OF DEATH

04883

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 69 College Park		d. STREET ADDRESS 5010 Luguna Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles A. Bradley				4. DATE OF DEATH Month Day Year April 2 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-15-11	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't Director of Personnel, N.L.R.B.		10b. KIND OF BUSINESS OR INDUSTRY Wash. D. C.		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George E. Bradley,				14. MOTHER'S MAIDEN NAME Katherine B. Bradley,			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Dorothy A. Bradley, wife,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 5 8/10 IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Porto-Caval Anastomosis (3 days post-operative) DUE TO (c) Cirrhosis of the Liver with bleeding esophageal varices unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1, 1961 , to 4-2-62 19..., that (I) (we) last saw the deceased alive on 4-2-62 , and that death occurred at 11:50 from the causes and on the date stated above.							
22a. SIGNATURE Dr. William C. Weintraub				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. William C. Weintraub				22d. ADDRESS 9 E Parkway Rd., Greenbelt, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/5/62		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEM.		23d. LOCATION (City, town or county) (State) ARLINGTON VA	
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth Haulon				ADDRESS 4748 Wisc Ave.		25a. REC'D BY REGISTRAR APR 9 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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CERTIFICATE OF DATA

Prince George

Chavaly

Donals

Donals

10 V. Soutway

Prince George's General Hospital

London

Frederick

23 30 33

James C. Monahan

1-20-02

1-20-02

Honolulu

Owa Home

Iowa

U.S.A.

Clara Barker

James C. Monahan

Navin C. Brandeburg, name as is (Knapton)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04886

04885

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Gee's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Run Hills		c. LENGTH OF STAY IN 1b 18- Months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 18 Oxon Run Hills		d. STREET ADDRESS 4913 - 28th Parkway S.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4913 - 28th Parkway S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY First A. Middle BRENNAN Last		4. DATE OF DEATH April Month 12th Day 19 Year 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10- 1878
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Parkhill		14. MOTHER'S MAIDEN NAME Mary J. McCarthy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Helene O. Masterson		Address Same as # 2. Dau.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr + 1 yr +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 13 1961 to April 12 1962 that (I) (we) last saw the deceased alive on April 12 1962, and that death occurred at 4 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James C. Cawood		22b. DATE SIGNED April 12, 1962	
22c. PHYSICIAN'S NAME (Type) JAMES C. CAWOOD		22d. ADDRESS 2520 Pa Ave S.E., Washington 20, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 16- 62	
23c. NAME OF CEMETERY OR CREMATORY St. Bonaventure Cemetery		23d. LOCATION (City, town, or county) (State) Olean, New York	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers		25a. REC'D BY REGISTRAR DATE APR 16 '62	
25b. REGISTRAR'S SIGNATURE William S. Thomas			

3223

CERTIFICATE OF DEATH

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1. Name of deceased: [illegible] 2. Date of death: [illegible] 3. Place of death: [illegible]

4. Cause of death: [illegible] 5. Age at death: [illegible]

6. Sex: [illegible] 7. Race: [illegible] 8. Marital status: [illegible]

9. Occupation: [illegible] 10. Education: [illegible]

11. Date of birth: [illegible] 12. Place of birth: [illegible]

13. Name of informant: [illegible] 14. Address of informant: [illegible]

15. Signature of informant: [illegible]

16. Name of physician: [illegible] 17. Address of physician: [illegible]

18. Signature of physician: [illegible]

19. Name of registrar: [illegible] 20. Address of registrar: [illegible]

21. Signature of registrar: [illegible]

22. Name of witness: [illegible] 23. Address of witness: [illegible]

24. Signature of witness: [illegible]

25. Name of witness: [illegible] 26. Address of witness: [illegible]

27. Signature of witness: [illegible]

28. Name of witness: [illegible] 29. Address of witness: [illegible]

30. Signature of witness: [illegible]

31. Name of registrar: [illegible] 32. Address of registrar: [illegible]

33. Signature of registrar: [illegible]

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FOR STATE
HEALTH DEPT.

04887

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04886

1. PLACE OF DEATH e. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 36 Carrollton	
c. LENGTH OF STAY IN b. D.O.A.		d. STREET ADDRESS 5908 85th. Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wayne Middle David Last Brinkley		4. DATE OF DEATH Month April Day 26 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 3, 1957
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min.	IF UNDER 24 HRS. Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ernest Halliard Brinkley	
14. MOTHER'S MAIDEN NAME Doris Mae Yingling		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Ernest Halliard Brinkley Address 5908 85th. Ave., Carrollton Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY OBSTRUCTION Conditions, if any, which gave rise to immediate cause (b) COMPRESSION OF TRACHEA (a), stating the underlying cause last. (c) TUMOR OF MEDIASTINUM			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/26/62	
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Paul C. Van Natta		M.D. Paul C. Van Natta, M.D.	
EXAMINER'S NAME (Type) Paul C. Van Natta, M.D.		Address (Street, city, town, or county) 7 Busch's Sons, Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jul 28-1962	
22c. NAME OF CEMETERY OR CREMATORY Whitfield		22d. LOCATION (City, town, or county) (State) Lanham Md	
23. FUNERAL DIRECTOR F Busch's Sons		24a. REC'D BY REGISTRAR APR 30 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

VR A15ME
5M 1/62

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

(M)

Prince George's

Maryland

Prince George's

Chesley

D.O.A.

Carrollton

Prince George's General Hospital

5908 85th Avenue

Wayne

Lavie

Prinley

April 60

Male White

Mar 2, 1957

8

None

None

Maryland

U.S.A.

Prince William Prinley

Doris Mae Prinley

None

West Hillside Prinley

Carrollton
5908 85th Ave
Maryland

RESEARCH OF
CONNECTIONS OF
TUBERCULOSIS

X

X

Paul G. Van Meter, M.D.

4/26/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04888 CERTIFICATE OF DEATH 04887											
Information from death cert.											
1. PLACE OF DEATH e. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE Maryland b. COUNTY Calvert ✓							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1day				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach 04X-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS General Del.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Britt				4. DATE OF DEATH Month April Day 7 Year 1962							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 April 1962		9. AGE (In years last birthday) yrs. 24		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Lafayette Britt				14. MOTHER'S MAIDEN NAME Margaret Grace McCoy							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 754-15		17. INFORMANT Mother		Address Same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Bilateral Pulmonary Atelectasis DUE TO 2. Congenital Heart Disease Conditions, if any, which gave rise to immediate cause (b) 754-15 (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
2De. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
2Dc. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from 6 Apr 1962 to 7 Apr 1962 , that (I) (we) last saw the deceased alive on 2 Apr 1962 , and that death occurred at 10 PM , from the causes and on the date stated above.											
22e. SIGNATURE R.R. Bassett M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) D.R. Sasscer., M.D.				22d. ADDRESS Upper Marlboro., Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4-13-62		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Pann, Jr., Administrator ADDRESS				25a. REC'D BY REGISTRAR APR 23 '62 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

2-046048

04287

STATE OF NEW YORK

1888

(M)

North River

1888

County

North River

1888

County

North River

1888

County

North River

1888

County

North River

1888

North River

1888

North River

1888

1. Minister of the Gospel

2. Minister of the Gospel

North River

1888

North River

1888

County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04889											
04888											
Item 23 Film 0312 5/1/62											
1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs				c. LENGTH OF STAY IN b 4 hrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF Hospital Andrews				d. STREET ADDRESS 2243 Chester St SE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BABY BOY				4. DATE OF DEATH Month Day Year April 25 1962							
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 April 62		9. AGE (In years last birthday) yrs. Months Days 4		IF UNDER 1 YEAR Months Days 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (County & State, or foreign country) Prince Georges, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Brown				14. MOTHER'S MAIDEN NAME Mabel R. Tabb							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Hospital Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity 776x DUE TO Conditions, if any, which gave rise to immediate cause (b) Prematurity (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (this hospital) attended the deceased from 25 April, 1962 to 25 April, 1962 that (s) (we) last saw the deceased alive on 25 April, 1962 and that death occurred at 2:25 P.M. from the causes and on the date stated above. 22e. SIGNATURE Nicholas P. Haritos M.D. 22c. PHYSICIAN'S NAME (Type) NICHOLAS P HARITOS, Capt USAF MC 22d. ADDRESS USAF HOSP, ANDREWS AIR FORCE BASE, MD 22b. DATE SIGNED 25 April 62 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremated 23b. DATE THEREOF April 26, 1962 23c. NAME OF CEMETERY OR CREMATORY DC Morgue 23d. LOCATION (City, town or county) (State) 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR DATE APR 27 '62 25b. REGISTRAR'S SIGNATURE Wm. S. Haritos											

2-068277

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04890

CERTIFICATE OF DEATH

04889

1. PLACE OF DEATH a. COUNTY Prince George's County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY PG	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hill Road, Landover, Md.	
c. LENGTH OF STAY IN 1b 12 days		d. STREET ADDRESS Hill Road, Landover, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernard F Brown		4. DATE OF DEATH Month 5 Day 5 Year 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-73
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 8 Days 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Landover Maryland	
11. BIRTHPLACE (County & State, or foreign country) Landover Maryland		12. CITIZEN OF WHAT COUNTRY? Landover Maryland	
13. FATHER'S NAME Richard Brown		14. MOTHER'S MAIDEN NAME Mildred J. Grabitt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs Bessie Brown - same as above.	
17. INFORMANT Mrs Bessie Brown - same as above.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Cerebral vascular accident DUE TO 260 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2. Cerebral arteriosclerosis DUE TO 10 yrs (c) 3. Diabetes mellitus	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 4-5 1962 to 7-8-62 1962 that (I) (we) last saw the deceased alive on 4-5 1962 and that death occurred at 9:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Peter Duus		22b. DATE SIGNED P.M.	
22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus		22d. ADDRESS 6124 Central Ave., Capitol Hgts., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-8-62	
23c. NAME OF CEMETERY OR CREMATORY Addison Chapel		23d. LOCATION (City, town or county) (State) Seat Pleasant, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE G. W. Lees		25a. REC'D BY REGISTRAR DATE APR 11 '62	
25b. REGISTRAR'S SIGNATURE Wash. D.C.		25c. REGISTRAR'S SIGNATURE Arthur S. Thomas	

04889

14820

M

James George's County

12 days

12 days

James George's County

Brook

Brook

10-1-73

Landover, Maryland

Landover, Maryland

Richard J. Smith

Richard J. Smith

James George's County - same as above

James George's County

1. Personal services rendered

2. Personal services rendered

3. Personal services rendered

4-2

4-2

Dr. James George

Dr. James George

James George's County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04891

CERTIFICATE OF DEATH

04890

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN b 4 1/2 mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Manor, 4922 La Salle Rd.		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE D.C. b. COUNTY Washington 9, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1629 Columbia Rd., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth Kent Brown		4. DATE OF DEATH April 20 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1888
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY ----	
13. FATHER'S NAME Miles Bainbridge King		14. MOTHER'S MAIDEN NAME Clara Kent	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clyde G. Brown (Husband)		18. BIRTHPLACE (County & State, or foreign country) Lincoln, Nebraska	
19. CITIZEN OF WHAT COUNTRY? U.S.A.		20. INTERVAL BETWEEN ONSET AND DEATH 7 yrs.	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) None		22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None	
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		24. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) None	
25. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		26. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		28. (City or town) (County) (State) Washington 9, D.C.	
29. I certify that (I) (the hospital) attended the deceased from Nov. 13 1957 to April 20, 1962 that (I) (we) last saw the deceased alive on April 16, 1962 , and that death occurred at 12:30 AM , from the causes and on the date stated above.			
30. SIGNATURE George Dewey M.D.		31. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 32. ADDRESS 1629 Columbia Rd., N.W., Washington 9, D.C.	
33. PHYSICIAN'S NAME (Type) George Dewey, M.D.		34. DATE 4/20/62	
35. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		36. DATE THEREOF 4-21-62	
37. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		38. LOCATION (City, town or county) (State) SUITLAND Md.	
39. FUNERAL DIRECTOR'S SIGNATURE JOSEPH GAWLER'S SONS, INC.		40. REC'D BY REGISTRAR APR 23 '62	
41. ADDRESS 1756 PENN. AVE. N.W. WASHINGTON 6, D.C.		42. REGISTRAR'S SIGNATURE Carlton S. Thomas	

01810

01810



George J. ...

Washington, D.C.

April 20, 1960

Washington, D.C.

George J. ...

Washington, D.C.

George J. ...

Washington, D.C.

April 20, 1960

28

George J. ...

Washington, D.C.

George J. ...

George J. ...

George J. ...

George J. ...

John

John

George J. ...

April 20, 1960

April 20, 1960

George J. ...

George J. ...

George J. ...

George J. ...

George J. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

BP

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04832						04891					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			d. STREET ADDRESS		
Prince George's			Cheverly			Em. Room			23 District Heights		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
Prince George's General Hospital						7800 District Hghts., Pkwy.					
3. NAME OF DECEASED (Type or print)			First			Middle			Last		
Anna			M.			Bruce			4. DATE OF DEATH		
5. SEX			6. COLOR OR RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH		
Female			White						11-12-27		
9. AGE (In years last birthday)			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
34			Telephone Operate			U.S. Gov't.			Maryland		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		
August Heimbuch			Kathryn Confort			No			214-24-8907		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) Complete Heartblock c) Rheumatic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						17. INFORMANT Address Kathryn Heimbuch 8139 Old Phila. Rd.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
19											
21. I certify that (I) (this hospital) attended the deceased from Dec. 15, 1961, to April 8, 1962, that (I) (we) last saw the deceased alive on April 8, 1962, and that death occurred at 11:55 from the causes and on the date stated above.											
22a. SIGNATURE Max M. Herzberg						22b. DATE SIGNED 4/11/62					
22c. PHYSICIAN'S NAME (Type) Dr. M. M. Herzberg						22d. ADDRESS 7016 Greigg Street, Seat Pleasant, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
Burial			4-18-62			GARDENS OF FAITH			Baltimore Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Carroll Riedel Md. Jff 1211 Chesaco Ave						25a. REC'D BY REGISTRAR DATE APR 17 '62			25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

04893

CERTIFICATE OF DEATH

04893

John Doe

John Doe

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04893

04892

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riversdale</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		
c. LENGTH OF STAY IN 1b <u>1 hr 10 min</u>		d. STREET ADDRESS <u>14018 Hamilton St</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Beland Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>August Eugene Burgess</u>		4. DATE OF DEATH <u>April 27 1962</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-88</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days		
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Herman E. Burgess</u>		14. MOTHER'S MAIDEN NAME <u>Katherine E. Grimm</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Record</u>		
17. INFORMANT <u>Hospital Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>592X</u> IMMEDIATE CAUSE (a) <u>nephritis chronic glom.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) }		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 1 1962</u> to <u>Apr 27 1962</u> ; that (I) (we) last saw the deceased alive on <u>4-27-62</u> and that death occurred at <u>08:00 P.M.</u> from the causes and on the date stated above.				
22a. SIGNATURE <u>Lionard Hays</u>		22b. DATE SIGNED <u>4-27-62</u>		
22c. NAME (Type) <u>LIONARD HAYS</u>		22d. ADDRESS <u>Hyattsville, Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 1, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>	23d. LOCATION (City, town or county) (State) <u>Colmar Manor Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gaska Sons</u>		25a. REC'D BY REGISTRAR <u>APR 30 '62</u>		
ADDRESS <u>Hyattsville, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>		

2000

12-5-4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04894

04893

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 20</u> d. STREET ADDRESS <u>D-1 Cypress Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carl J Cain</u>		4. DATE OF DEATH <u>April 29 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/21/1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Ret.) Internal Rev. Ser.</u>		9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>NEBRASKA</u>	
13. FATHER'S NAME <u>John Cain</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah Winkler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>359-07-2279</u>	
17. INFORMANT <u>Mrs. Loretta Cain, D-1, Cypress Drive, ZONE 20</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia (whole Left Brain)</u> 43414 DUE TO (b) <u>Arteriosclerosis Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>L/Ventricle Hypertrophy</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>62</u> to <u>4/29</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>4/29</u> , 19 <u>62</u> , and that death occurred at <u>2:10</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Hei K. Lee</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>HEI K. LEE</u>		22d. ADDRESS <u>7732 ANNAPOLIS RD. LANHAM, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-4-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>William Cook</u> ADDRESS		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>MAY 4 '62</u>	
25b. REGISTRAR'S SIGNATURE			

4-1883

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John Smith

John Smith

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04895 CERTIFICATE OF DEATH 04894

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural (Glenn Dale) c. LENGTH OF STAY IN 1b 2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1348 C Street, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAVID - CALDWELL First Middle Last		4. DATE OF DEATH April 28 1962 Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Legally separated	8. DATE OF BIRTH December 25, 1910 9. AGE (In years last birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafeteria Helper		10b. KIND OF BUSINESS OR INDUSTRY Eastern High School	11. BIRTHPLACE (County & State, or foreign country) Lawrence, S.C.
13. FATHER'S NAME Peter Caldwell		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME Carrie French		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown	
16. SOCIAL SECURITY NO. 577-14-5161		17. INFORMANT Person	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage 002-1 } DUE TO Conditions, if any, which gave rise to immediate cause (b) Pulmonary Tuberculosis (e), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 minutes 2 yrs., 4 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/4 1960 to 4/28 1962, that (I) (we) last saw the deceased alive on 4/28 1962, and that death occurred at 2:35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 4/28/62	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-2-62	23c. NAME OF CEMETERY OR CREMATORY HARMONY NIEMI, PK	23d. LOCATION (City, town or county) (State) 7601 SHERIFF RD, N.E. MD.
24. FUNERAL DIRECTOR'S SIGNATURE HOFFMAN FUN'L HOME		25a. REC'D BY REGISTRAR APR 30 '62	25b. REGISTRAR'S SIGNATURE Arthur L. Harris

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U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04896

04895

Item 9 Film G312 5/1/62 mh

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>58 Hyattsville, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2022 Lewisdale Drive</u>		d. STREET ADDRESS <u>2022 Lewisdale Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Lulu</u> <u>Gertrude</u> <u>Cowles</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 8, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Hartford, Conn.</u>
13. FATHER'S NAME <u>Hosea Potter</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Aldenhofen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Alden Cowles</u>		Address <u>2022 Lewisdale Dr. Hyattsville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Carcinoma of rectum</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 26</u> , 19 <u>62</u> to <u>April 23</u> , 19 <u>62</u> , that (I) (was) last saw the deceased alive on <u>April 23</u> , 19 <u>62</u> , and that death occurred at <u>1:45 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman H. Rubenstein</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4/23/62</u>
22c. PHYSICIAN'S NAME (Type) <u>NORMAN H. RUBENSTEIN</u>		22d. ADDRESS <u>6480 N.H. Ave. TAKOMA PARK, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Apr 5, 1962</u>	23c. NAME OF CEMETERY OR CREMATOR <u>Spring Grove</u>	23d. LOCATION (City, town or county) (State) <u>Hartford Connecticut</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>I. Gasch's Sons</u>		25a. REC'D BY REGISTRAR DATE <u>APR 25 '62</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

01895

UNITED STATES OF AMERICA

1895

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UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04897

04896

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN b. 12 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl Curtin		4. DATE OF DEATH April 26 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 April 1962
9. AGE (In years last birthday) 12		IF UNDER 1 YEAR Months Days 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jackson Marshall		14. MOTHER'S MAIDEN NAME Glenda Jean Lobaugh Curtin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. Same as above	
17. INFORMANT Mother		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pulmonary Atelectasis DUE TO Bilateral Adrenal Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 771.0 (b) 771.0 (c) 771.0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH Life	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 4/25 1962		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5,404 N		20f. (City or town) Hyattsville, Md. (County) Prince Georges (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 4/25 1962 to 4/26 1962 that (I) (we) last saw the deceased alive on 4/25 1962 , and that death occurred at 5,404 N from the causes and on the date stated above.			
22a. SIGNATURE Dr. Joseph J. McDonald		22b. DATE SIGNED 4/26/62	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph J. McDonald		22d. ADDRESS 7309 Riggs Rd., W. Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF May 5, 1962	
23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) Cheverly, Maryland (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator		25a. REC'D BY REGISTRAR MAY 8 '62 DATE 4/26/62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04898						04897					
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b. 2½ days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 30 District Heights d. STREET ADDRESS 724 - 60th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Baby Girl "A"			4. DATE OF DEATH Month April Day 25 Year 1962			5. SEX Female			6. COLOR OR RACE Colored		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH April 23, 1962			9. AGE (In years last birthday) yrs. 2 Months 8 Days 40			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Unknown Whetler Kellibrew		
14. MOTHER'S MAIDEN NAME Yvonne Deale			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT Mother Address Same as above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) Bilateral Pulmonary Atelectasis (a), stating the underlying cause last. DUE TO (c) Prematurity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) life life life 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 4/23 , 1962 to 4/25 , 1962, that (I) (we) last saw the deceased alive on 4/25 , 1962, and that death occurred at 5:28 , from the causes and on the date stated above. 22a. SIGNATURE Dr. Joseph J. McDonald M.D. 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 7309 Riggs Rd., W. Hyattsville, Md. 22e. DATE SIGNED 4/26/62 22f. MED. M. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 5 May 1962			23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital			23d. LOCATION (City, town or county) (State) Cheverly, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE H. W. Penn, Jr., Administrator						25a. REC'D BY REGISTRAR MAY 8 '62			25b. REGISTRAR'S SIGNATURE Curtis S. Kraus		

2-046540

04887

00228

(M)

(C)

(S)

1. Name of the person or organization to whom the report is made
2. Name of the person or organization making the report
3. Date of the report
4. Title of the report
5. Summary of the report
6. Details of the report
7. Conclusion of the report
8. Signature of the person making the report
9. Name and position of the person making the report
10. Name and position of the person to whom the report is made

11. Name of the person or organization to whom the report is made
12. Name of the person or organization making the report
13. Date of the report
14. Title of the report
15. Summary of the report
16. Details of the report
17. Conclusion of the report
18. Signature of the person making the report
19. Name and position of the person making the report
20. Name and position of the person to whom the report is made

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04899						04898					
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 7 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 District Heights d. STREET ADDRESS 724-60th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Baby Girl (B" Deale						4. DATE OF DEATH Month Day Year April 30 19 62					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-23-62		9. AGE (In years last birthday) yrs. 7		IF UNDER 1 YEAR Months Days Hours Min. 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wheeler Kallibrew						14. MOTHER'S MAIDEN NAME Yvonne Deale					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address Same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 4/23 1962 , to 4/30 1962 that (I) (we) last saw the deceased alive on 4/30 1962 , and that death occurred 2:55M , from the causes and on the date stated above.											
22a. SIGNATURE Dr. Salvatore Battiatia M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. Salvatore Battiatia						22d. ADDRESS 7309 Riggs Rd., Hyattsville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5-8-62		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Peen, Jr., Administrator						25a. REC'D BY REGISTRAR MAY 8 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

2-046538

11

CERTIFICATE OF DEATH

Reg. Dist. No. 04899

04800

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>58 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2418-Kirston street</u>		d. STREET ADDRESS <u>2418-Kirston street</u>	
3. NAME OF DECEASED (Type or print) <u>Lucille J. Dennis</u>		4. DATE OF DEATH <u>4-24-1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 2, 1921</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY W. ROSIE</u>		14. MOTHER'S MAIDEN NAME <u>MAUDE BARNES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>John H. Dennis Jr. Husband</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> 1977-9 DUE TO <u>Leiomyosarcoma Inferior Vena Cava</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>2 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 61</u> to <u>4-24-62</u> , that I last saw the deceased alive on <u>4-24-1962</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jerome H. Epstein</u>		ADDRESS (Street, city or town, state) <u>2025 EYE ST, NW</u>	
PHYSICIAN'S NAME (Type) <u>FEROME H. EPSTEIN, MD</u>		DATE SIGNED <u>WASH 6, 1962</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>4-27-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery, Suitland, Maryland</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home, Inc.</u>		24a. DEC'D BY REGISTRAR <u>DATE APR 30 '62</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

04300

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>University Hills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>59 University Hills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3415 Stanford Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>THEODORE</u> Middle <u>W</u> Last <u>DENT</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-1900</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerical</u>		11. BIRTHPLACE (State or foreign country) <u>DRAYDEN, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James W Dent</u>				14. MOTHER'S MAIDEN NAME <u>Mary G Combs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-36-8062</u>		17. INFORMANT <u>Beatrice Jones Dent</u> Address <u>3415 Stanford University Hills</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6-15-61</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>6-15-61</u> , 19____, to <u>4-15</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>4-15-62</u> , 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John P. Clum</u> M.D.				ADDRESS (Street, city or town, state) <u>Hyattsville Md</u> DATE SIGNED <u>4/16/62</u>			
PHYSICIAN'S NAME (Type) <u>JOHN P. CLUM, M.D.</u>				6110 43rd Avenue, Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-18-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Em</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.</u>				ADDRESS <u>Riverdale, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 18 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>		<p>5. PLACE OF BIRTH [Faint text]</p>	
<p>6. OCCUPATION [Faint text]</p>		<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>		<p>9. MANNER OF DEATH [Faint text]</p>		<p>10. PLACE OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF DECEASED [Faint text]</p>		<p>12. SIGNATURE OF WITNESS [Faint text]</p>		<p>13. SIGNATURE OF DECEASED [Faint text]</p>		<p>14. SIGNATURE OF WITNESS [Faint text]</p>		<p>15. SIGNATURE OF DECEASED [Faint text]</p>	
<p>16. SIGNATURE OF WITNESS [Faint text]</p>		<p>17. SIGNATURE OF DECEASED [Faint text]</p>		<p>18. SIGNATURE OF WITNESS [Faint text]</p>		<p>19. SIGNATURE OF DECEASED [Faint text]</p>		<p>20. SIGNATURE OF WITNESS [Faint text]</p>	
<p>21. SIGNATURE OF DECEASED [Faint text]</p>		<p>22. SIGNATURE OF WITNESS [Faint text]</p>		<p>23. SIGNATURE OF DECEASED [Faint text]</p>		<p>24. SIGNATURE OF WITNESS [Faint text]</p>		<p>25. SIGNATURE OF DECEASED [Faint text]</p>	
<p>26. SIGNATURE OF WITNESS [Faint text]</p>		<p>27. SIGNATURE OF DECEASED [Faint text]</p>		<p>28. SIGNATURE OF WITNESS [Faint text]</p>		<p>29. SIGNATURE OF DECEASED [Faint text]</p>		<p>30. SIGNATURE OF WITNESS [Faint text]</p>	
<p>31. SIGNATURE OF DECEASED [Faint text]</p>		<p>32. SIGNATURE OF WITNESS [Faint text]</p>		<p>33. SIGNATURE OF DECEASED [Faint text]</p>		<p>34. SIGNATURE OF WITNESS [Faint text]</p>		<p>35. SIGNATURE OF DECEASED [Faint text]</p>	
<p>36. SIGNATURE OF WITNESS [Faint text]</p>		<p>37. SIGNATURE OF DECEASED [Faint text]</p>		<p>38. SIGNATURE OF WITNESS [Faint text]</p>		<p>39. SIGNATURE OF DECEASED [Faint text]</p>		<p>40. SIGNATURE OF WITNESS [Faint text]</p>	
<p>41. SIGNATURE OF DECEASED [Faint text]</p>		<p>42. SIGNATURE OF WITNESS [Faint text]</p>		<p>43. SIGNATURE OF DECEASED [Faint text]</p>		<p>44. SIGNATURE OF WITNESS [Faint text]</p>		<p>45. SIGNATURE OF DECEASED [Faint text]</p>	
<p>46. SIGNATURE OF WITNESS [Faint text]</p>		<p>47. SIGNATURE OF DECEASED [Faint text]</p>		<p>48. SIGNATURE OF WITNESS [Faint text]</p>		<p>49. SIGNATURE OF DECEASED [Faint text]</p>		<p>50. SIGNATURE OF WITNESS [Faint text]</p>	
<p>51. SIGNATURE OF DECEASED [Faint text]</p>		<p>52. SIGNATURE OF WITNESS [Faint text]</p>		<p>53. SIGNATURE OF DECEASED [Faint text]</p>		<p>54. SIGNATURE OF WITNESS [Faint text]</p>		<p>55. SIGNATURE OF DECEASED [Faint text]</p>	
<p>56. SIGNATURE OF WITNESS [Faint text]</p>		<p>57. SIGNATURE OF DECEASED [Faint text]</p>		<p>58. SIGNATURE OF WITNESS [Faint text]</p>		<p>59. SIGNATURE OF DECEASED [Faint text]</p>		<p>60. SIGNATURE OF WITNESS [Faint text]</p>	
<p>61. SIGNATURE OF DECEASED [Faint text]</p>		<p>62. SIGNATURE OF WITNESS [Faint text]</p>		<p>63. SIGNATURE OF DECEASED [Faint text]</p>		<p>64. SIGNATURE OF WITNESS [Faint text]</p>		<p>65. SIGNATURE OF DECEASED [Faint text]</p>	
<p>66. SIGNATURE OF WITNESS [Faint text]</p>		<p>67. SIGNATURE OF DECEASED [Faint text]</p>		<p>68. SIGNATURE OF WITNESS [Faint text]</p>		<p>69. SIGNATURE OF DECEASED [Faint text]</p>		<p>70. SIGNATURE OF WITNESS [Faint text]</p>	
<p>71. SIGNATURE OF DECEASED [Faint text]</p>		<p>72. SIGNATURE OF WITNESS [Faint text]</p>		<p>73. SIGNATURE OF DECEASED [Faint text]</p>		<p>74. SIGNATURE OF WITNESS [Faint text]</p>		<p>75. SIGNATURE OF DECEASED [Faint text]</p>	
<p>76. SIGNATURE OF WITNESS [Faint text]</p>		<p>77. SIGNATURE OF DECEASED [Faint text]</p>		<p>78. SIGNATURE OF WITNESS [Faint text]</p>		<p>79. SIGNATURE OF DECEASED [Faint text]</p>		<p>80. SIGNATURE OF WITNESS [Faint text]</p>	
<p>81. SIGNATURE OF DECEASED [Faint text]</p>		<p>82. SIGNATURE OF WITNESS [Faint text]</p>		<p>83. SIGNATURE OF DECEASED [Faint text]</p>		<p>84. SIGNATURE OF WITNESS [Faint text]</p>		<p>85. SIGNATURE OF DECEASED [Faint text]</p>	
<p>86. SIGNATURE OF WITNESS [Faint text]</p>		<p>87. SIGNATURE OF DECEASED [Faint text]</p>		<p>88. SIGNATURE OF WITNESS [Faint text]</p>		<p>89. SIGNATURE OF DECEASED [Faint text]</p>		<p>90. SIGNATURE OF WITNESS [Faint text]</p>	
<p>91. SIGNATURE OF DECEASED [Faint text]</p>		<p>92. SIGNATURE OF WITNESS [Faint text]</p>		<p>93. SIGNATURE OF DECEASED [Faint text]</p>		<p>94. SIGNATURE OF WITNESS [Faint text]</p>		<p>95. SIGNATURE OF DECEASED [Faint text]</p>	
<p>96. SIGNATURE OF WITNESS [Faint text]</p>		<p>97. SIGNATURE OF DECEASED [Faint text]</p>		<p>98. SIGNATURE OF WITNESS [Faint text]</p>		<p>99. SIGNATURE OF DECEASED [Faint text]</p>		<p>100. SIGNATURE OF WITNESS [Faint text]</p>	

This certificate is to be filled out by the physician or other person authorized by the State Board of Health. It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of Vital Statistics. The certificate should be filled out in duplicate, and the original should be filed in the office of the Registrar of Vital Statistics. The duplicate should be filed in the office of the physician or other person authorized by the State Board of Health.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04902

04901

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oxen Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Beland Memorial Hospital</u>		d. STREET ADDRESS <u>6245 St. Barnabas Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Herschel Eugene Dishner, Jr</u>		4. DATE OF DEATH Month Day Year <u>April 18 1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11, 1956</u>
9. AGE (in years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>California</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herschel E. Dishner, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Marguerite E. Behrens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 550.1 DUE TO <u>generalized peritonitis - toxic heart</u> Conditions, if any, which gave rise to immediate cause (b) <u>Suppurative gangrenous appendicitis</u> (c) <u>8</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>8</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-10</u> , 19 <u>62</u> to <u>4-18</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4-18</u> , 19 <u>62</u> , and that death occurred at <u>4-18</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Howland F. Wilkinson</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Howland F. Wilkinson</u>		22d. ADDRESS <u>4408 Queensbury Road Riverdale, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-21-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Nat'l Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Falls Church, Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Hittingly</u>		ADDRESS <u>131-112 St Wash DC</u>	
25a. REC'D BY REGISTRAR <u>APR 24 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. France</u>	

500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04903

04902

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Forest Heights</u>	
c. LENGTH OF STAY IN 1b <u>7 yrs</u>		d. STREET ADDRESS <u>340 Cree Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>340 Cree Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELIZA</u> Middle <u>AUGUSTA</u> Last <u>DOWNS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 23, 1887</u>
9. AGE (In years lost, birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Sween</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Stevens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Howard F. Downs</u>		Address <u>L.a., b., & above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> (c) <u>General Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1960</u> to <u>April 29, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 29, 1962</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry G. Hadley</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>HENRY G. HADLEY MD</u>		22d. ADDRESS <u>4601 Nichols Ave St L</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 2, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 3 '62</u>	
ADDRESS <u>317 Pa. Ave., SE Wash. 3, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

31712

CERTIFICATE OF DEATH

1990

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1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04904

04903

1. PLACE OF DEATH a. COUNTY Prince George's County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly, Md. c. LENGTH OF STAY in 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 63 5213 Baltimore Ave., Hyattsville, Md. d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wesley W. WAYNE Downs, Sr.		4. DATE OF DEATH Month 4 Day 17 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-15-1901
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 60 Days 00	11. IF UNDER 24 HRS. Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Specialist Dept of Army		11. BIRTHPLACE (County & State, or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Wesley Wayne Downs, Jr. Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO 260X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerosis Heart Disease (c) Diabetes Melitus		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 16, 1962 , to April 17, 1962 , that (I) (we) last saw the deceased alive on April 17, 1962 , and that death occurred at 4:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Peter Duus M.D.		22b. DATE SIGNED April 18, 1962	
22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus		22d. ADDRESS 6124 Central Avenue, Capitol Heights, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-21-62	
23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City, town or county) (State) Switzland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 5801 Cleveland Ave., Md.		25a. REC'D BY REGISTRAR DATE APR 24 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thane			



1948

1948

Prince George's County

Prince George's County

Prince George's County

Greenville, N.C.

2515 Hollinsworth Ave., Greenville, N.C.

Prince George's County, Maryland

DATE: 1-1-1961

TO: Mr. J. Edgar Hoover

FROM: Mr. J. Edgar Hoover

The subject of this letter is the...
...of the...
...of the...

Enclosed for your information are...
...of the...

Very truly yours,
J. Edgar Hoover

April 24, 1961

Mr. J. Edgar Hoover

2515 Hollinsworth Ave., Greenville, N.C.

Enclosed for your information are...
...of the...
...of the...

1
FOR STATE
HEALTH DEPT.

TO FURNISH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04905 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04904

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN IT 18			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. STREET ADDRESS 5776 26th., Avenue			
3. NAME OF DECEASED (Type or print) Julius Klor Draheim		First Middle Last		4. DATE OF DEATH April 30, 1962		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1916	9. AGE (in years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't Machinist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julius Draheim				14. MOTHER'S MAIDEN NAME Adeline Stallman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 11 578-09-5679		17. INFORMANT Rose Draheim Address Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Vascular disease (c) unknown							INTERVAL BETWEEN ONSET AND DEATH Sudden Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) natural causes					
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Paul C. Van Natta				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/30/62	
EXAMINER'S NAME (Type) PAUL C. VAN NATTA, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 3-62		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl.	
22d. LOCATION (City, town, or country) (State) Arlington Va.				23. FUNERAL DIRECTOR Simmons Bros. Funeral Home		24a. REC'D BY REGISTRAR MAY 3 '62	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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Prince George's General Hospital
Overly
Maryland
Prince George's

Johns Hopkins
April 30, 1916
East 30, 1916
U.S.A.

Johns Hopkins
See W. M. 575-07-675
Johns Hopkins
U.S.A.

Johns Hopkins
U.S.A.

Johns Hopkins
U.S.A.

Johns Hopkins
U.S.A.

Johns Hopkins
U.S.A.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the funeral director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM
SM 1/62

04906

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04905

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph Ernest Dube				4. DATE OF DEATH April 5th., 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 11, 1917	
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 4 Days 5		11. IF UNDER 24 HRS. Hours 5 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Maintainer W.S.S.C.				10b. KIND OF BUSINESS OR INDUSTRY Extor, New Hampshire			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Cleophus Dube				14. MOTHER'S MAIDEN NAME Anna St. Jean			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 003-01-9698			
17. INFORMANT Mrs. Louise E. Dube, College Park, Md.				Address 9719 53rd Ave.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 MYOCARDIAL INFARCTION CORONARY ARTERY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 4/5/62			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF April 9, 1962		22c. NAME OF CEMETERY OR INTERMENT PLACE Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO. Riverdale, Md.				24a. REC'D BY REGISTRAR APR 11 '62			
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

MEDICAL CERTIFICATION

04905

04905

Prince George's
Maryland

College Park
Cheverly



Prince George's General Hospital
2519 5th Avenue

John
Duke

Male
White

Personnel
U.S.A.



John
U.S.A.

John
U.S.A.

James I. Hux, M.D.
James I. Hux, M.D.

X

X

X

JAMES I. HUX, M.D.

James I. Hux, M.D.

James I. Hux, M.D.

James I. Hux, M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Heverly			c. LENGTH OF STAY IN lb 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS P.O. Box 3303			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Stephen HURLEY Duck			First Middle Last		4. DATE OF DEATH April 3 19 62		Month Day Year						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 21 -1886		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10b. KIND OF BUSINESS OR INDUSTRY Painting House			11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A				
13. FATHER'S NAME unknown					14. MOTHER'S MAIDEN NAME unknown								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no			16. SOCIAL SECURITY NO. ,		17. INFORMANT William Henry Dale Address 3902 81st ave Forestville, Md								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of right hip 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiovascular renal disease										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs										
20c. TIME OF INJURY Month, Day, Year 8 00 a.m. 2-2 19 62			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Upper Marlboro, P.G., Maryland		(County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd			M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 4-3-62		
EXAMINER'S NAME (Type) Dr. James I. Boyd			Address (Street, city, town, or county) W.W. Chambers Co Riverdale, Md.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 4-7-1962		22c. NAME OF CEMETERY OR CREMATORY Washington National			22d. LOCATION (City, town, or county) Suitland, Maryland			(State)		
23. FUNERAL DIRECTOR W.W. Chambers Co					ADDRESS		24a. REC'D BY REGISTRAR APR 6 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Frouse				

(M)

1. The first part of the document is a list of names and addresses, which are arranged in a columnar fashion. The names are written in a cursive hand, and the addresses are written in a more formal, printed style. The list appears to be a directory or a roster of some kind.

2. The second part of the document is a series of paragraphs, each beginning with a heading. The headings are written in a cursive hand, and the paragraphs are written in a more formal, printed style. The paragraphs appear to be a report or a letter of some kind.

3. The third part of the document is a series of paragraphs, each beginning with a heading. The headings are written in a cursive hand, and the paragraphs are written in a more formal, printed style. The paragraphs appear to be a report or a letter of some kind.

4. The fourth part of the document is a series of paragraphs, each beginning with a heading. The headings are written in a cursive hand, and the paragraphs are written in a more formal, printed style. The paragraphs appear to be a report or a letter of some kind.

5. The fifth part of the document is a series of paragraphs, each beginning with a heading. The headings are written in a cursive hand, and the paragraphs are written in a more formal, printed style. The paragraphs appear to be a report or a letter of some kind.

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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04909

04908

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
e. COUNTY Prince George's MARYLAND				a. STATE New Jersey b. COUNTY Camden			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Runnemeade			
c. LENGTH OF STAY IN 1b DOA				d. STREET ADDRESS #19 11th Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DELLA AMANDA DUNGAN				4. DATE OF DEATH April 3 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH October 3, 1887 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Candymaker		10b. KIND OF BUSINESS OR INDUSTRY Candy		11. BIRTHPLACE (State or foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Ayers				14. MOTHER'S MAIDEN NAME Amanda			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Wayne M. Milligan			
17. INFORMANT 9522 Washington Blvd. Seabrook, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Chronic occlusion							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Coronary artery disease							
DUE TO (c) Cardiovascular renal disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes, obesity							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i>				DATE SIGNED 4/3/62			
EXAMINER'S NAME (Type) JAMES I. BOYD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF April 7, 1962			
22c. NAME OF CEMETERY OR CREMATORY Hillside Cemetery				22d. LOCATION (City, town, or county) Roslyn Pa			
23. FUNERAL DIRECTOR F. Gasch's Sons				24a. REC'D BY REGISTRAR APR 6 '62			
ADDRESS Hyattsville, Md.				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

01908



James B. Smith
James B. Smith

Arthur S. Kraus

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[Handwritten signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
04911														
04910														
1. PLACE OF DEATH e. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY in 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 28 Seat Pleasant			d. STREET ADDRESS 6113 St. Margaret Dr.						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) JOAN First Louise Middle Baby Girl "B" Edwards					4. DATE OF DEATH Month April Day 8 Year 1962									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 April 1962		9. AGE (In years last birthday) 4						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant (none)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James L. Edwards					14. MOTHER'S MAIDEN NAME Frances Louise Horman									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Hospital Records Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular - Respiratory Insufficiency 773.5 DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH 4 days				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from 4-4-62 to 4-8-62 , that (I) (we) last saw the deceased alive on 4-7-62 and that death occurred at 7:00AM from the causes and on the date stated above.														
22a. SIGNATURE Dr. Peter Duus, M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-8-62							
22c. PHYSICIAN'S NAME (Type) Dr. P. Duus, M.D.					22d. ADDRESS 6124 Central A ve., Capitol Heights, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-62		23c. NAME OF CEMETERY OR CREMATORY Ft. Linclon Cemetery			23d. LOCATION (City, town or county) (State) Prince Georges, County, MD.							
24. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins					ADDRESS 3821-14th St. N.E.		25a. REC'D BY REGISTRAR DATE APR 11 '62		25b. REGISTRAR'S SIGNATURE William S. M...					

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Approved: _____

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04912
04911
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cottage City	
c. LENGTH OF STAY in 1b 5 days		d. STREET ADDRESS 3708 37th Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Virginia T E Fell		4. DATE OF DEATH April 29 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Oct. 1889 72 yrs.
9. AGE (in years last birthday) 72		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U S Treasury		10b. KIND OF BUSINESS OR INDUSTRY Washington D C	
11. BIRTHPLACE (County & State, or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Dalrymple		14. MOTHER'S MAIDEN NAME Priscella Torbert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Hospital records	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (b) arteriosclerotic heart disease		8 years	
(a), stating the underlying cause last. (c) chronic congestive heart failure			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Heretofore rheumatic heart disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1, 1956, to Apr 29, 1962, that (I) (we) last saw the deceased alive on Apr 28, 1962, and that death occurred at 6:15 AM from the causes and on the date stated above.			
22a. SIGNATURE Till Bergemann M.D.		22b. DATE SIGNED 4/29/62	
22c. PHYSICIAN'S NAME (Type) Dr. Till Bergemann, M.D.		22d. ADDRESS 53 D Crescent Rosa Greenbell M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1962	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town or county) Colmar Manor, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
ADDRESS Hyattsville, Md.		DATE MAY 1 '62 Arthur S. Evans	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04912

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Shirley Mae Harley Ford		4. DATE OF DEATH Month Day Year April 24 19 62	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-56
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Prince George Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Proctor		14. MOTHER'S MAIDEN NAME Elizabeth Harley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. *****	
17. INFORMANT Address Maryland Elizabeth Ford - Rt. 1- Box 68 Mitchellville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Toxemia Secondary Infection</i> 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Multiple and extensive Burns all body</i> DUE TO (c) <i>-----</i>			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Clothe caught fire while Burning a Water</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>4:19 1962</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Mitchellville Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Paul C. Van Natta</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>PAUL C. VAN NATTA</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED	
		Address (Street, city, town, or county) <i>Pr Geo Co. Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 27-62	22c. NAME OF CEMETERY OR CREMATORY Holy Family Catholic	22d. LOCATION (City, town, or country) (State) Mitchellville- Md.
23. FUNERAL DIRECTOR Charles E. Hicks 111 Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE MAY 2 '62	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

MEDICAL CERTIFICATION

16

2



04914

CERTIFICATE OF DEATH

Reg. Dist. No. 04913

1. PLACE OF DEATH a. COUNTY <u>Prince Georges Hospital</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly MD</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>66 East Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges' Hosp</u>				d. STREET ADDRESS <u>5406- 62nd Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GERALD</u> Middle <u>WINFRED</u> Last <u>FOSTER</u>				4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>19 62</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/4/82</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent Brick yard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brick yard</u>		11. BIRTHPLACE (State or foreign country) <u>Pennia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Foster</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ingoldsby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>177-01-7499</u>		17. INFORMANT <u>Mrs Jean Boswell</u> Address <u>same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8</u> DUE TO <u>GENERALIZED CARCINOMATOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA of COLON.</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>1960</u> , 19____, to <u>4-3-</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>4-3-62</u> , 19____, and that death occurred at <u>8:00</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albert Roth</u>		M.D. <u>5510 MADISON ST RIVERDALE</u>		DATE SIGNED <u>4-3-62</u>			
PHYSICIAN'S NAME (Type) <u>Albert Roth</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-7-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kittanning Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Kittanning Pennia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers Co. Riverdale</u>				24a. REC'D BY REGISTRAR <u>APR 8 1962</u>		24b. REGISTRAR'S SIGNATURE <u>W W Chambers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the funeral director. Page 1, 2, and 3 to be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04915											
04914											
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS Box 363					
3. NAME OF DECEASED (Type or print) ROBERT VERNON FOWLER						4. DATE OF DEATH April 30, 19 62					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 22, 1959		9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY Child				11. BIRTHPLACE (State or foreign country) Cheverly, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vernon Monroe Fowler						14. MOTHER'S MAIDEN NAME Dorothy Alexander					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. None					
17. INFORMANT Mrs. Vernon M. Fowler, Lanham, Md.						Address Box 363					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Toxic Broncho Pneumonia 085.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Menses (a), stating the underlying cause last. DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none of note INTERVAL BETWEEN ONSET AND DEATH 2 weeks											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Paul C. Van Natta						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) PAUL C. VAN NATTA, M.D.						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED May 1, 1962					
22a. BURIAL OR CREMATION (Specify) Burial						22b. DATE THEREOF May 4, 1962					
22c. NAME OF CEMETERY Arlington National Cemetery						22d. LOCATION (City, town, or country) Arlington, Virginia					
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.						24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Anthony S. Thomas					
DATE MAY 3 '62											

(M)

Prince Georges

Maryland

Prince Georges County

Lanham

D.C.A.

Overly

Box 563

Prince Georges General Hospital

YOWLER

ROBERT VERNON

Male White

Nov. 28, 1953

Child

Child

Overly, Maryland

Robert Alexander

Vernon Robert Fowler

None

None

Mrs. Vernon M. Fowler, Lanham, Md.

Box 563

PAUL C. VAN HATTA, M.D.

W. W. CHAMBERS CO., Hiverville, Md.

May 1, 1953

Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 10, 11, 12, 13 & 14 Film G213 5/17/62 mh

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 Cedar Heights d. STREET ADDRESS 6230 Lee Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Tracy Garrison		4. DATE OF DEATH Month Day Year April 27 19 62	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-3-09
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY South Carolina	
11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Press Garrison		14. MOTHER'S MAIDEN NAME Georgia Mathais	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Edmon		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) severe hypertension (a), stating the underlying cause last. DUE TO (c) urine		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/22 , 19 62 to 4/27 , 19 62 that (I) (we) last saw the deceased alive on 4/27 , 19 62 , and that death occurred at 7:15 , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Caesar M. Madarang		22b. DATE SIGNED A.M.	
22c. PHYSICIAN'S NAME (Type) Dr. Caesar M. Madarang		22d. ADDRESS Prince George's General Hospital, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 1, 1962	
23c. NAME OF CEMETERY OR CREMATORY NATL HARMONY PARK		23d. LOCATION (City, town or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Cameron Fun. Home		25a. REC'D BY REGISTRAR DATE MAY 4 '62	
ADDRESS 611 K St. N.W.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

01912

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Lyndon B. Johnson

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04917

04916

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (East Pines) Riverdale	
c. LENGTH OF STAY in 1b 15 minutes		d. STREET ADDRESS 6609 Oliver Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Lorena GIBSON		4. DATE OF DEATH Month Day Year April 7, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 25, 1896
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days -- --	
IF UNDER 24 HRS. Hours Min. -- --			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Y.M.C.A.	
11. BIRTHPLACE (County & State, or foreign country) Dinwiddie County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S. of Am.	
13. FATHER'S NAME Samuel Johnson		14. MOTHER'S MAIDEN NAME Mary Lou Lengford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No --		16. SOCIAL SECURITY NO. 579-28-2704A	
17. INFORMANT Russel M. Carrell		Address 6609 Oliver St., Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerosis Generalized		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 10 years 30 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. -- -- 19 --		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that (I) (this hospital) attended the deceased from October 11, 1961 to April 7, 1962 , that (I) (we) last saw the deceased alive on March 27, 1962 , and that death occurred at 1:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Walcutt W. Gibson M.D.		22b. DATE SIGNED April 7, 1962	
22c. PHYSICIAN'S NAME (Type) Walcutt W. Gibson, M.D.		22d. ADDRESS 4340 St. Barnabas Road, Washington 21, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE See Funeral Home 300. 4th st N.E.		25a. REC'D BY REGISTRAR DATE APR 11 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

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FOR STATE
HEALTH DEPT.

any delay is necessary, the State Department of Health after death, pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. This is to be done in the presence of the funeral director. Page 5 may be retained for your files. The pages 1 and 2 with the State Department of Health permit. The pages 3 and 4 should be used for the funeral director. Page 5 should be used for the funeral director. Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04918 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04917

1. PLACE OF DEATH e. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				f. STREET ADDRESS 4013 Longfellow Street			
3. NAME OF DECEASED (Type or print) Sidney				4. DATE OF DEATH April 26, 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1917	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR 44 Months		IF UNDER 24 HRS. 44 Days		IF UNDER 24 HRS. 44 Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metallurgist				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
11. BIRTHPLACE (State or foreign country) New Jersey				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Aaron Gottley				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W. 11			
17. INFORMANT Norval Eugene Jones, 209 Bradley Ave.,				Address Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion							
(b) Coronary Vascular Heart Disease							
(c) unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none that I know							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> et work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Paul C. Van Natta				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul C. Van Natta, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 4/26/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/28/1962			
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				22d. LOCATION (City, town, or country) (State) Prince Georges County, Md.			
23. FUNERAL DIRECTOR The S.H.Hines Co.-2901 14th St., N.W.				24a. REC'D BY REGISTRAR APR 30 '62			
ADDRESS Washington 9, D.C.				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

MEDICAL CERTIFICATION

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1. *Explain the importance of the following factors in the development of a country's economy:*

1990-1991

Chen et al.

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Prince George's General Hospital

4-018 Lancaster 1000 Street

2003.1.16

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June 13, 1917.

References

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2705-2713

Rockville, MD

II. W. W. RAY

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1991-1992

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04919

04918

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
e. COUNTY Prince George
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE Maryland
b. COUNTY Prince George | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Chesverly | | c. LENGTH OF STAY IN 1b
10 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince George General Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Rosie Middle Graham Last Graham | | 4. DATE OF DEATH
Month Apr. Day 10 Year 19 62 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 5, 1878 |
| 9. AGE (in years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months 41 Days 41 Hours 41 Min. 41 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home | |
| 11. BIRTHPLACE (Country & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Charles Harrison | | 14. MOTHER'S MAIDEN NAME
Not Obtainable | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
Mrs. Mrs. Elsie Van Alstyne | |
| 17. INFORMANT
Same as above | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
4-20-0 DUE TO (b) Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
10 min.
10 yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour e.m. Month, Day, Year 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/31 , 19 62 to 4/10 , 19 62 ; that (I) (we) last saw the deceased alive on 4/10 , 19 62 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
F. E. Mosser M.D. | | 22b. DATE SIGNED
A pr. 10 1962 | |
| 22c. PHYSICIAN'S NAME (Type)
F. E. Mosser | | 22d. ADDRESS
4410 74th Ave. Souderton, Pa. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
13 April 62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Methodist Protestant | | 23d. LOCATION (City, town or county) (State)
Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
W. Bandy Mountcastle | | 25a. REC'D BY REGISTRAR
APR 13 '62 | |
| ADDRESS
Alex., Va. | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Hanna | |

04018

INSTITUTE OF DATA

04018



1
FOR STATE
HEALTH DEPT.
(M)
77
I
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, the De-
puty Medical Examiner should execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04920 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04919

| | | | |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN b 2 Hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland
f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Landover Hills
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Albert Middle Paul Last Grimshaw | | 4. DATE OF DEATH
Month April Day 16 Year 19 62 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 29, 1956
yrs. 5 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles Gerald Grimshaw | | 14. MOTHER'S MAIDEN NAME Janet Landgraf | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Charles Gerald Grimshaw, same as # 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hemorrhage and shock
Conditions, if any, which gave rise to immediate cause (b) Compound fracture of the skull
(a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Ran out from in front of a parked parked truck on road | |
| 20c. TIME OF INJURY
Month, Day, Year 4/16/62
Hour 2:50 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road | | 20f. (City or town) Landover (County) P. G. (State) Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE James I. Boyd | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) James I. Boyd | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/20/62 | |
| 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 22d. LOCATION (City, town, or country) (State) Pr. Georges Co., Maryland | |
| 23. FUNERAL DIRECTOR The S.H. Hines Co., 2901 14th St. N.W., Wash. D.C. | | 24a. REC'D BY REGISTRAR APR 18 '62 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | DATE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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04921
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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04920

| | | | |
|--|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> | | c. LENGTH OF STAY IN 1b <u>2 yrs-10 mos</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | 51 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5008-36th Ave.</u> | | d. STREET ADDRESS <u>5008-36th Ave.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>PERCY</u> Middle <u>LEE</u> Last <u>HALE</u> | | 4. DATE OF DEATH
Month <u>APRIL</u> Day <u>29</u> Year <u>1962</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DEC 16, 1880</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, D.C. Government</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John H. Hale</u> | | 14. MOTHER'S MAIDEN NAME <u>Josephine ?</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>Ms. Ena Spencer</u> | |
| 17. INFORMANT <u>E. Daughter</u> | | Address <u>above</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>
DUE TO
(c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u>
<u>many</u> YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>AUG 1, 1961</u> to <u>PRESENT</u> 19 <u>62</u> , that (I) (we) lost the deceased alive on <u>APRIL 21, 1962</u> and that death occurred at <u>10³⁰ PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Paul A. DeVore</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>29 APR 1962</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>PAUL A. DEVORE, M.D.</u> | | 22d. ADDRESS <u>3501 HAMILTON ST., HYATTSVILLE, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>5/3/62</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u> | | 23d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u> | | 25a. REC'D BY REGISTRAR <u>May 3 '62</u> DATE | |
| 25b. REGISTRAR'S SIGNATURE <u>Conrad S. Fuma</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
6/15/62
mnb

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04922
07353
CERTIFICATE OF DEATH

| | | | |
|---|--------------------------|--|--------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rheverly | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mitchelville | |
| c. LENGTH OF STAY IN 1b 13 days | | d. STREET ADDRESS Rt. #2, Box 41 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospice, give street address) Prince George's General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Henry O. Harley | | 4. DATE OF DEATH April 3 19 62 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-19-53 |
| 9. AGE (In years last birthday) 9 yrs. | | 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Wallace Harley | | 14. MOTHER'S MAIDEN NAME Helen Turner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Helen Turner, Mitchelville, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 201X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Hodgkins Disease
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH 670. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-21 1962, to 4-3 1962, that (I) (we) last saw the deceased alive on 4-3 1962, and that death occurred at 11:55 AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Peter Duus | | 22b. DATE SIGNED 4/3/62 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus | | 22d. ADDRESS 6124 Central Ave., Capitol Hgts., Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4/7/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mt. Nebo | | 23d. LOCATION (City, town or county) (State) Mitchelville, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE George G. Kelson, Aquasco, Md. | | 25a. REC'D BY REGISTRAR DATE JUL 5 '62 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kears | | | |

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04923 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04921

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
b. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marguerite Ave., Off Glendale Rd. | | | | d. STREET ADDRESS off Marguerite Ave., Glendale Rd. | | | |
| 3. NAME OF DECEASED (Type or print) Douglas Nesbet Haselden | | | | 4. DATE OF DEATH April 24, 19 62 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 3, 1913 | |
| 9. AGE (In years last birthday) 48 | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY Barry Industries | | | |
| 11. BIRTHPLACE (State or foreign country) So. Carolina | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Stephen Osgood Haselden | | | | 14. MOTHER'S MAIDEN NAME Rosa Lee Marlow | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 317-01-6882 | | | |
| 17. INFORMANT Mary Eleanor Haselden | | | | Address Same as #2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARBON MONOXIDE POISONING
Conditions, if any, which gave rise to immediate cause (b) 9733
(c) 3
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year 12:20 a.m. 4/24 19 62 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Residence | | 20f. (City or town) Glendale (County) P.G. (State) Maryland. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Paul C. Van Natta | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) PAUL C. VAN NATTA, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF April 27, 1962 | | | |
| 22c. NAME OF CEMETERY OR CORNER St Georges Episcopal | | | | 22d. LOCATION (City, town, or country) Glendale, Md. (State) | | | |
| 23. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville Md. | | | | 24a. REGISTRY REGISTRATION APR 30 1962 24b. REGISTRAR'S SIGNATURE Arthur L. Hume | | | |

VR A15ME
5M 1/62

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be noted in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Life pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

Prince George's

Prince George's

Prince George's

Glendale

14 yrs.

Glendale

Marquette Ave., 611 Glendale St., Marquette Ave., Glendale St.

Don Jan Nelson Hazelton

Male White Oct. 3, 1913 43

Steph Clark

Betty Industries So. Carolina

U.S.A.

Stephen Conrad Hazelton

Home Lee Nelson

No 117-01-8882 Mary Eleanor Hazelton Same as 43

CHARLES MEMORIAL

X

117-01-8882

X Kell...

Glendale

Glendale

X

X

X

V

PAT C. VAN NATTA, N.O.

117-01-8882

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the Deputy Medical Examiner, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

12
FOR STATE
HEALTH DEPT
M

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
049224 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 049222

| | | | |
|--|------------------------|--|-------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) District Heights | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkland | |
| c. LENGTH OF STAY IN 1b D.O.A. | | d. STREET ADDRESS 112 Druid Place | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) District Heights Medical Center | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last | | 4. DATE OF DEATH Month Day Year | |
| Nevin Robert Haudenschild | | April 16th. 19 62 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 5, 1910 |
| 9. AGE (In years last birthday) 51 yrs. | | 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | |
| 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Ray Eugene Haudenschild | | 14. MOTHER'S MAIDEN NAME Grace Sohn | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 276-03-8988 | |
| 17. INFORMANT Mary Kirkwood, 112 Druid Place | | Address Parkland, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 444X Acute congestive heart failure
Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease.
(c) DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTORY <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE James I. Boyd | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) JAMES I. BOYD, M.D. | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-19-1962 | |
| 22c. NAME OF CEMETERY OR CREMATORY GREENLAWN CEMETERY | | 22d. LOCATION (City, town, or country) Tiffin, Ohio | |
| 23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md. | | 24e. REC'D BY REGISTRAR APR 18 '62 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hanna | |

14755

14755

Prince George's

Director Heilman

D. C. A.

Director Heilman Medical Center

Kevin

Robert

Handman

White

M

June 8, 1960

Donation

Ohio

Key to the Handman

Ohio

275-2-7000

Acute congestive heart failure

Cardiac arrest

x

x

x

JAMES I. ROY, M.D.

AMERICAN UNIVERSITY (formerly American University)

W. R. Heilman, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

1
04925

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04923

Item 9 Film G311 4/17/62 mh

| | | | | | | | | | | | | | | | |
|--|--|-------------------------------------|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY in lb
12 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
35 Glen Arden
d. STREET ADDRESS
8627 Johnson Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Sarah | | First
Sarah | | Middle
Hawkins | | Last
Hawkins | | 4. DATE OF DEATH
Month
April
Day
6
Year
19 62 | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6-27-1893 | | 9. AGE (In years last birthday)
68 yrs. | | IF UNDER 1 YEAR
Months
68
Days
68 | | IF UNDER 24 HRS.
Hours
68
Min.
68 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
St Marys Co. Ind. | | | | 11. BIRTHPLACE (County & State, or foreign country)
U.S.A. | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
John Barbare | | | | 14. MOTHER'S M maiden name
Emma M. Dawson | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
Emma M. Washington | | | |
| 17. INFORMANT
Emma M. Washington | | | | | | | | | | | | Address
Emma M. Washington | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
4-20-62 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
(County)
(State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-6 , 19 62 , to 4-6 , 19 62 that (I) (we) last saw the deceased alive on 4-6 , 19 62 , end that death occurred at 3:30 P.M. from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
Peter Duus
M.D. | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
April 7, 1962 | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Peter Duus, M.D. | | | | | | 22d. ADDRESS
6124 Central Ave., Capitol Heights, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-10-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Carmen Memorial Park | | | | 23d. LOCATION (City, town or county)
Ind
(State) | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
4804 E. A. HETJOHNSON S. J. ENKINS | | | | | | 25a. REC'D BY REGISTRAR
APR 11 '62 | | 25b. REGISTRAR'S SIGNATURE
Charles L. Hines | | | | | | | |

0-1353

(M)

10 hours
8557 Johnson, Walter
10 hours
8557 Johnson, Walter

10 hours
8557 Johnson, Walter
10 hours
8557 Johnson, Walter

Antisocialist Front
Bureau of
Antisocialist Front
Bureau of

10 hours
8557 Johnson, Walter
10 hours
8557 Johnson, Walter

10 hours
8557 Johnson, Walter
10 hours
8557 Johnson, Walter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04926

04924

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glenn Dale (rural)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Glenn Dale Hospital | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE
D. C.
b. COUNTY
-
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington
d. STREET ADDRESS
4113 Beck St., S.E.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Ashton N. Hewitt | | 4. DATE OF DEATH
Month Day Year
4 30 19 62 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Separated, not legally
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1/13/1888 |
| 9. AGE (In years last birthday)
74 yrs. | | 10. IF UNDER 1 YEAR
Months Days
- - | 11. IF UNDER 24 HRS.
Hours Min.
- - |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Checker's Helper | | 10b. KIND OF BUSINESS OR INDUSTRY
Safeway | |
| 11. BIRTHPLACE (County & State, or foreign country)
Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Richard Hewitt | | 14. MOTHER'S MAIDEN NAME
Anna Brown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
No | | 16. SOCIAL SECURITY NO.
577-12-6145 | |
| 17. INFORMANT
Decedent | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary hemorrhage
002.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Pulmonary tuberculosis
(c) DUE TO
(e), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
1 hr.,
9 yrs., 9 mo | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
Arteriosclerotic heart disease | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/10/1952 , to 4/30/1962 , that (I) (we) last saw the deceased alive on 4/30/1962 , and that death occurred at A.M. , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Moe Weiss
M.D. | | 22b. DATE SIGNED
4/30/1962 | |
| 22c. PHYSICIAN'S NAME (Type)
Moe Weiss, M.D. | | 22d. ADDRESS
Glenn Dale Hospital
Glenn Dale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
May 2, 1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Richmond Church Cemetery | | 23d. LOCATION (City, town or county) (State)
Stafford Co. Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
F. Sarchi Son | | 25a. REDD BY REGISTRAR
DATE MAY 4 '62 | |
| ADDRESS
4731 Ball Ave, Hyattsville, Md. | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Harris | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

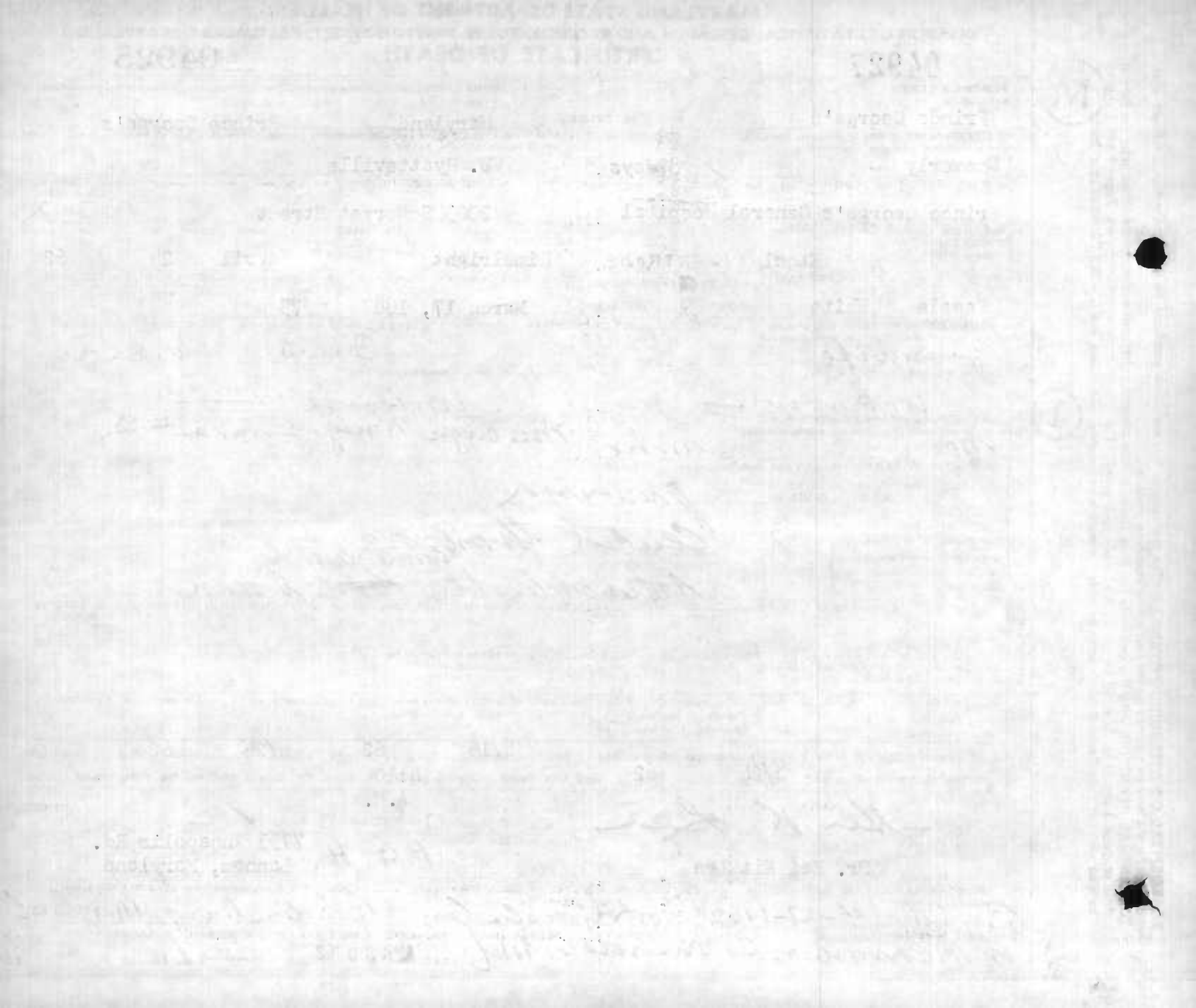
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04927

04925

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY in 1b
8 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
51 W. Hyattsville
d. STREET ADDRESS
2003 Somerset Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Ethel GERTRUDE Himelright | | 4. DATE OF DEATH
Month Day Year
April 24 19 62 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED
<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 17, 1887 |
| 9. AGE (In years last birthday)
75 yrs. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Iowa | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
unknown | | 14. MOTHER'S MAIDEN NAME
unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Address
Mrs Olga Krug. Same as #2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
premenstrual
Cerebral thrombosis
Arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 4/16, 1962, to 4/24, 1962, that (I) (we) last saw the deceased alive on 4/24, 1962, and that death occurred at 4:10 A.M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Hei K. Lee
M.D. | | 22b. DATE SIGNED
APR 30 '62 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Hei Kit Lee | | 22d. ADDRESS
P.G.H. 7733 Annapolis Rd.
Lanham, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-27-1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cem | | 23d. LOCATION (City, town or county) (State)
Bladensburg, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
M.M. Chambers Co Riverdale, Md | | 25a. REC'D BY REGISTRAR
DATE APR 30 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur L. Thomas | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04928

04926

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
e. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cheverly</u> | | c. LENGTH OF STAY IN 1b
<u>2 hours</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Maryland Park</u> | | d. STREET ADDRESS
<u>6523 Coolidge Street</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Prince Georges General Hospital</u> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>William T Hogue Sr.</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>April 21 19 62</u> | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>28 Oct. 1887</u> | | 9. AGE (In years last birthday)
<u>74</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired CARPENTER BUILDING</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Wash. D.C.</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>U.S.A</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | | | |
| 13. FATHER'S NAME
<u>GEORGE W. HOGUE</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>ANNIE HUTCHINSON</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT
<u>LILLIAN O. FERRITER</u> | | Address <u>6736 MARLBORO PIKE SE</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction (Lower left ventricle)</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Left coronary arteriosclerotic occlusion</u>
DUE TO (c) <u>Pulmonary edema, bilateral</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour e.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 21</u> , 19 <u>62</u> , to <u>April 21</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>April 21</u> , 19 <u>62</u> , and that death occurred at <u>1:45 AM</u> from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>William Brainin</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>WM BRAININ</u> | | | | 22d. ADDRESS
<u>6124 Central Ave, Capital Hyge Inc</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>4-24-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cem</u> | | 23d. LOCATION (City, town or county)
<u>Southland Md.</u> | | (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>W. W. Chambers Co. Washington D.C.</u> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <u>APR 25 '62</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hanks</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04326

04326

George W. Hoge

William C. Feltner

John C. Feltner

John C. Feltner

John C. Feltner

John C. Feltner

John C. Feltner

John C. Feltner

John C. Feltner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04929 CERTIFICATE OF DEATH 04927

| | | | |
|--|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE Maryland COUNTY Prince George's
Washington, D. C. County | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
10 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince George's General Hospital | | d. STREET ADDRESS
513-68th Place (Seat Pleasant) | |
| 3. NAME OF DECEASED
(Type or print)
Clifford C. Hooker | | 4. DATE OF DEATH
Month April Day 23 Year 19 62 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-26-1900 |
| 9. AGE (In years last birthday)
61 yrs. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | 10b. KIND OF BUSINESS OR INDUSTRY
Painting | |
| 11. BIRTHPLACE (County & State, or foreign country)
Arlington, Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
William Hooker | | 14. MOTHER'S MAIDEN NAME
Mattilda Bear | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO. (If as giver or data of service)
Anna B. Hooker | |
| 17. INFORMANT
Anna B. Hooker | | Address above
Wife | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis
162.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Bronchogenic Carcinoma
(c) Metastasis to brain. Lt adrenal gland, Lt kidney. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/31 , 19 62 , to 4/23 , 19 62 , that (I) (we) last saw the deceased alive on 4/23 , 19 62 , and that death occurred 10:00 from the causes and on the date stated above. | | 22a. SIGNATURE
Max M. Herzberg
M.D. | |
| 22b. DATE SIGNED
APR 27 1962 | | 22c. PHYSICIAN'S NAME (Type)
Dr. Max M. Herzberg | |
| 22d. ADDRESS
7016 Greig St., Seat Pleasant, Maryland | | 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/26/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet | | 23d. LOCATION (City, town or county) (State)
Washington, D.C. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Malley's Funeral Home
Sonc, | | 25a. REC'D BY REGISTRAR
DATE APR 27 1962 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur L. Prince | | | |

(M)

(1)

04983

04983

James G. Gentry

James G. Gentry

1000

1000

1000

1000

Clifford

Clifford

1000

1000

William Hooker

William Hooker

William Hooker

William Hooker

William Hooker

William Hooker

William Hooker

William Hooker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04930

04928

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission)
e. STATE <u>D.C.</u> b. COUNTY <u>✓</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Carroll Manor Hyattsville Md.</u> | | d. STREET ADDRESS
<u>2700 Conn. Ave N.W.</u> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>Josephine Sarah Horigan</u> | | 4. DATE OF DEATH
Month Day Year
<u>April 11 1962</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan. 28 1883</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>Washington D.C.</u> |
| 13. FATHER'S NAME
<u>James T. Clements</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sarah Jett</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT
<u>Sister Agnes Patricia</u> | | Address
<u>Carroll Manor</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)
<u>Respiratory Collapse</u>
DUE TO
<u>Cerebral Thrombosis (repeated episodes)</u>
DUE TO
<u>Cerebral Arteriosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>at death</u>
<u>1 week</u>
<u>8 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
p.m.
<u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (his hospital) attended the deceased from <u>2 April 1962</u> to <u>11 April 1962</u> , that (I) (we) last saw the deceased alive on <u>10 April 1962</u> , and that death occurred at <u>12:45 P.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Louis A Craig Jr.</u> | | 22b. DATE SIGNED
<u>12 April 62</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>LOUIS A. CRAIG, JR.</u> | | 22d. ADDRESS
<u>1746 K ST N.W.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>4/24/62</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Rood Cemetery</u> | 23d. LOCATION (City, town or county) (State)
<u>Washington D.C.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>H. Don. DeVol</u> | | 25a. REC'D BY REGISTRAR
<u>APR 19 '62</u> | |
| ADDRESS
<u>2224 - Wisconsin Ave NW</u> | | 25b. REGISTRAR'S SIGNATURE
<u>William S. Rouse</u> | |

(M)

05930

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STANDARD OIL COMPANY

D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04931

CERTIFICATE OF DEATH

04929

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGES</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SUITLAND</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>15 Washington</u> | |
| c. LENGTH OF STAY in 1b
<u>WKS.</u> | | d. STREET ADDRESS
<u>302 Quade St.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>SUITLAND NURSING HOME</u> | | a. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>MARGARET M. HOUSE</u> | | 4. DATE OF DEATH
Month Day Year
<u>April 21 1962</u> | |
| 5. SEX
<u>F.</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>JUNE 8 1924</u> |
| 9. AGE (In years last birthday)
<u>37</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days
<u>- -</u> | 11. IF UNDER 24 HRS.
Hours Min.
<u>- -</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>William Morgan</u> | | 14. MOTHER'S MAIDEN NAME
<u>BERTHE BOYETTE</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>243-30-1202</u> | |
| 17. INFORMANT
Address
<u>HOSPITAL RECORDS</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Malnutrition</u>
<u>1530</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma descending colon</u>
(a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 17, 1962</u> to <u>April 21, 1962</u> that (I) (we) last saw the deceased alive on <u>4/17</u> 1962 , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Dr. Etienne Szollosi</u> M.D. | | 22b. DATE SIGNED
<u>APR 25 '62</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>DR. ETIENNE SZOLLOSI M.D.</u> | | 22d. ADDRESS
<u>2 PARKWAY N. Washington 21-DC</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>4-24-62</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Falls Church Va Nat Mem Park Cemetery</u> | 23d. LOCATION (City, town or county) (State) |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Lee Funeral Home</u> | | 25a. REC'D BY REGISTRAR
<u>300-4 ST NE WASH D.C.</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur L. Kenna</u> | | | |

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, place and execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04932 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04930

| | | | | | |
|---|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Bowie | | |
| c. LENGTH OF STAY IN
DOA | | | d. STREET ADDRESS
10th and Zug Road | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince George's General Hospital | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Hazel Virginia Howard | | | 4. DATE OF DEATH
Month Day Year
April 18 19 62 | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 25, 1902 | 9. AGE (In years last birthday)
59 yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Oden Howard Dugan | | | 14. MOTHER'S MAIDEN NAME
Rosena Watts | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Address
Lewis Everett Howard, same as # 2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute congestive heart failure
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Coronary heart disease
DUE TO
(c) Cardiovascular renal disease | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes of long standing | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
James I. Boyd | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
April 18, 1962 | |
| EXAMINER'S NAME (Type)
James I. Boyd | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
4/21/62 | | 22c. NAME OF CEMETERY OR CREMATORY
Lynch Hill Cem. | |
| 22d. LOCATION (City, town, or country) (State)
Lanham Md | | 23. FUNERAL DIRECTOR
Address
He Witt Davidson, Lanham, Md | | | |
| 24a. REC'D BY REGISTRAR
APR 24 '62 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Hume | | | |

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MEDICAL CERTIFICATION

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1
FOR STATE
HEALTH DEPT.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, pages 1, 2, and 3 to the funeral director. Page 4 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04931

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince George
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Suitland
c. LENGTH OF STAY IN b
2 1/2 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
5110 Logan Street | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Suitland
d. STREET ADDRESS
5110 Logan Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
CHARLES
f. SEX
Male
g. COLOR OR RACE
White
h. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
i. DATE OF BIRTH
Sept 26 1908
j. AGE (In years last birthday)
53 yrs.
k. IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/>
l. IF UNDER 24 HRS.
Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | 4. DATE OF DEATH
April 10 1962
m. MONTH
April
n. DAY
10
o. YEAR
1962 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Brick Mason
10b. KIND OF BUSINESS OR INDUSTRY
N.C.
11. BIRTHPLACE (State or foreign country)
N.C.
12. CITIZEN OF WHAT COUNTRY?
U.S.A./ | | 13. FATHER'S NAME
Manson
14. MOTHER'S MAIDEN NAME
Laura Bass | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
none
16. SOCIAL SECURITY NO.
577 07*4408
17. INFORMANT
Mrs Hattie Hudgins
Address
Wife | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Congestion
DUE TO Carcinoma of Lung
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. unknown
DUE TO unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
None | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
3 days
9 Mon | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19
20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
James E. Chapman
EXAMINER'S NAME (Type)
James E. Chapman | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
10 Apr 62
Address (Street, city, town, or county)
2026 RST NW Wash DC | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial
22b. DATE THEREOF
4/12/62
22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery
22d. LOCATION (City, town, or country) (State)
Suitland Maryland | | 23. FUNERAL DIRECTOR
Lee Funeral Home
ADDRESS
300 4th, St. N.E. Washington, D.C.
24a. REC'D BY REGISTRAR
APR 13 '62
24b. REGISTRAR'S SIGNATURE
Arthur S. House | |

UNITED STATES
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

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1
FOR STATE
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

04934

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04932

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>14 Oxon Hill</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6317 Dominion Drive</u> | | | | d. STREET ADDRESS <u>16317 Dominion Drive</u> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Ernestina Galvez Huici</u> | | | | 4. DATE OF DEATH
Month <u>April</u> Day <u>10</u> Year <u>1962</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 13, 1879</u> | |
| 9. AGE (in years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Spain</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>Spain</u> | | | | | | | |
| 13. FATHER'S NAME <u>Manuel Galvez</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ortega</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Miguel Huici, same as #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
DUE TO (b) <u>Coronary vascular disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u> </u> p.m. <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED <u>April 10, 1962</u> | | | |
| ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| Address (Street, city, town, or county) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL <u>Cremation</u> | | 22b. DATE HEREOF <u>4/11/62</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u> | | 22d. LOCATION (City, town, or country) (State) <u>Bladensburg, Md.</u> | |
| 23. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u> | | | | 24a. REC'D BY REGISTRAR <u>APR 13 '62</u> | | | |
| 24b. REGISTRAR'S SIGNATURE <u>Charles L. Kraus</u> | | | | | | | |

MEDICAL CERTIFICATION

THE
MILITARY

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RECEIVED
JAN 11 1911
U.S. DEPT. OF WAR
OFFICE OF THE ADJUTANT GENERAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|---|--|--|---|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | |
| 04935 | | | | | 04933 | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) | | | | | |
| a. COUNTY
PRINCE GEORGES | | | | | a. STATE
MARYLAND | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANDREWS AIR FORCE BASE | | | | | b. COUNTY
Anne Arundel | | | | | |
| c. LENGTH OF STAY IN 1b
1 DAY | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
DEALE | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
US AIR FORCE HOSPITAL ANDREWS | | | | | d. STREET ADDRESS
BOX 48 DEALE BEACH | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | 4. DATE OF DEATH | | | | | |
| First Middle Last
INFANT BOY INMAN | | | | | Month Day Year
APRIL 14 1962 | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
CAUCASIAN | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12 APRIL 1962 | | 9. AGE (In years last birthday) yrs.
1 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 10b. KIND OF BUSINESS OR INDUSTRY
NONE | | 11. BIRTHPLACE (County & State, or foreign country)
PRINCE GEORGES, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 13. FATHER'S NAME
JACK D INMAN | | | | | 14. MOTHER'S MAIDEN NAME
MARY L MILLS | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | | | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ATELECTASIS, CONGENITAL
762-5 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) PREMATURE BIRTH
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
32 HOURS | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
(County)
(State) | | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12 APRIL , 19 62 , to 14 APRIL , 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 14 APRIL , 19 62 , and that death occurred at 4AM , from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
John A Moore | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
14 APRIL 1962 | | | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN A MOORE, Major USAF MC | | | | | 22d. ADDRESS
USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-18-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Hill | | 23d. LOCATION (City, town or county)
7d myer Va | | (State) | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
W. W. Chambers | | | | | ADDRESS
517-112-2P SE | | 25a. REC'D BY REGISTRAR
DATE
APR 18 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

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04003

CENTRAL OF CHINA

04003

US AIR FORCE HOSPITAL ADDRESS

DAY 8 HEALTH RECORD

1 DAY

ADDRESS AIR FORCE HOSPITAL

HEALTH

MALE

CONSTITUTION

12 APRIL 1962

ASST

HEALTH

NONE

NONE

MARY J. WILLY

JOHN D. LEMAN

NONE

ATTESTATION, CONSENT

PRESENCE BIRTH

22 HOURS

10 APRIL

12 APRIL

10 APRIL

JOHN A. MOORE, Major USAF MC

USAF HOSPITAL, ADDRESS AIR FORCE HOSPITAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04936

CERTIFICATE OF DEATH

Reg. Dist. No.

04934

| | | | |
|---|---------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>49 Mt. Rainier</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3717-34th Street</u> | | d. STREET ADDRESS <u>3717-34th Street</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Elva Matilda Johannes</u> First Middle Last | | 4. DATE OF DEATH <u>April 29</u> Month Day Year <u>1962</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/29, 1882</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles Harting</u> | | 14. MOTHER'S MAIDEN NAME <u>Ida Hoeger</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>216-22-2164</u> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Emphysema of Lungs, Advanced</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>INTERTROCHANTERIC FRACTURE RIGHT Femur 6 wks</u>
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardio Vascular Disease</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1/4</u> , 19 <u>61</u> , to <u>4/29</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>4/10</u> , 19 <u>62</u> , and that death occurred at <u>10:30</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D. | | ADDRESS (Street, city or town, state) <u>3503 Perry St.</u> DATE SIGNED <u>4/30/62</u> | |
| PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEAU</u> | | <u>Mt Rainier Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>5/2/62</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home, Inc.</u> ADDRESS <u>Mt Rainier Md</u> | | 24a. REC'D BY REGISTRAR <u>MAY 3 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04937

Item 5 from birth certificate

CERTIFICATE OF DEATH

04935

| | | | | | | | |
|---|--------------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b 42 Hrs. 47 Min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland
d. STREET ADDRESS 23 Randall Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Baby Boyl Johnson | | 4. DATE OF DEATH April 5 19 62 | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 3, 1962 | 9. AGE (In years last birthday) 1
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (County & State, or foreign country) Cheverly Prince George's Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME Harold Eugene Johnson | | | 14. MOTHER'S MAIDEN NAME Wilma Gray Johnson | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mother Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
762.5 DUE TO Bilateral Atelectasis
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last, } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-3, 1962 to 4-5, 1962 that (I) (we) last saw the deceased alive on 4-5, 1962, and that death occurred at 12:05 from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE John W. Perkins
22c. PHYSICIAN'S NAME (Type) Dr. John W. Perkins | | | 22b. DATE SIGNED A.M.
22d. ADDRESS 5301 Hamilton Street, Hyattsville, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4/6/62 | | 23c. NAME OF CEMETERY OR CREMATORY Johnson Family Burial Plot | | | |
| 23d. LOCATION (City, town or county) Newton Grove Rd #2 | | 23e. REC'D BY REGISTRAR DATE APR 9 '62 | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home | | 25a. REGISTRAR'S SIGNATURE Caroline S. House | | 25b. REGISTRAR'S SIGNATURE | | | |

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FOR STATE
HEALTH DEPT.

04938

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04936

| | | | | | |
|---|----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH
e. COUNTY Prince Georges County MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. Brentwood | | |
| c. LENGTH OF STAY IN b. DOA | | | d. STREET ADDRESS 4703 WEBSTER ST | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hosp. | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
WILLMORE JOSEPH JOHNSON | | | 4. DATE OF DEATH
Month Day Year
April 24, 1962 | | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
NOV 26, 1914 | | 9. AGE (in years last birthday)
47 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Trash Truck | 11. BIRTHPLACE (State or foreign country)
St. Mary's Cty. Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Ernest Johnson | | | 14. MOTHER'S MAIDEN NAME
Annie Briscoe | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW II | | 16. SOCIAL SECURITY NO.
579-c9-9009 | | 17. INFORMANT
Mrs. Bessie Queen, Address Route #1 Box 185 Lanham, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LOBAR PNEUMONIA
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b)
DUE TO
(c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a.m. p.m.
19 | Month, Day, Year
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town)
ARLINGTON, VIRGINIA | (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <i>Paul C. Van Natta</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED |
| EXAMINER'S NAME (Type) PAUL C. VAN NATTA, M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | April 24, 1962 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
4-30-62 | 22c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL CEM. | | 22d. LOCATION (City, town, or country) (State)
ARLINGTON, VIRGINIA |
| 23. FUNERAL DIRECTOR
John T. Rhines & Company | | | 24a. REC'D BY REGISTRAR
APR 30 '62 | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur L. Rhines</i> |

VR A15ME
5M 1/62

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be noted in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04930



Prince Georges County Maryland Prince Georges

Chesley DOA V. Brantwood

Prince Georges General Hosp.

WILLIAM JOSEPH JOHNSON

April 21

Mary Harris

Inspector

Tenth Creek St. Mary's City, Md.

U.S.A.

Annie Brantwood

James Johnson

Box 11

Unknown is Mr. Joseph Quinn, Landon, Va.

House #1 Box 115 Landon, Va.

LEARN P. C. 11.11.11

X

X

X

X

X

APRIL 21, 1962

PAUL O. VAN MATR, M.D.

WASHINGTON NATIONAL CO. LANDROV, VIRGINIA

John T. Wilson & Company 2014 10th St. N.W. Wash. D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04939

CERTIFICATE OF DEATH

04937

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale
c. LENGTH OF STAY IN 1b 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hosp. | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md.
b. COUNTY Prince Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg 40
d. STREET ADDRESS 4405-56th Ave 1
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Laura W
First Middle Last
4. DATE OF DEATH Month 4 Day 4 Year 1962 | | 5. SEX Female
6. COLOR OR RACE wh.
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6-6-1914
9. AGE (In years last birthday) 47 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tab. Project Planner - Govt. worker
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME William H. Wheatley
14. MOTHER'S MAIDEN NAME Frances Burkhardt | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Hospital Records. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 171X PNEUMONIA
DUE TO (b) Metastatic Carcinoma to Lungs.
DUE TO (c) Carcinoma of Cervix
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (e), STATING THE UNDERLYING CAUSE LAST. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 2 months 10 months | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that (II) (this hospital) attended the deceased from March 1961, to April 1962 that (II) (we) last saw the deceased alive on 3 April 1962, and that death occurred at 5 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Thomas M. Hutchin M.D.
22c. PHYSICIAN'S NAME (Type) Thomas M Hutchin | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22b. DATE SIGNED 4-4-62
22d. ADDRESS 7315 Landover Rd. Hyattsville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 4/7/62
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill
23d. LOCATION (City, town or county) (State) Suitland, Maryland | | 24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons
ADDRESS Hyattsville, Maryland
25a. REC'D BY REGISTRAR DATE APR 6 '62
25b. REGISTRAR'S SIGNATURE Arthur L. Kline | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04940

04938

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY PRINCE GEORGES MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY PRINCE GEORGES | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANDREWS AIR FORCE BASE | | | | c. LENGTH OF STAY IN 1b
X CAMP SPRINGS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
USAF HOSPITAL ANDREWS | | | | d. STREET ADDRESS
5571 MAXWELL DRIVE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First DAWN Middle MARIE Last KENNEDY | | | | 4. DATE OF DEATH
Month APRIL Day 3 Year 1962 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
CAUCASIAN | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
27 December 1960 | |
| 9. AGE (In years last birthday) yrs. 1 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | | | 10b. KIND OF BUSINESS OR INDUSTRY
NONE | | 11. BIRTHPLACE (State or foreign country)
PHILIPPINE ISLANDS | |
| 13. FATHER'S NAME
THOMAS JAMES KENNEDY | | | | 14. MOTHER'S MAIDEN NAME
BEATRICE A FREESE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
NA | | 17. INFORMANT
THOMAS J SMITH(FATHER) SAME AS #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
75 4 5 IMMEDIATE CAUSE (a) Congestive failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital heart disease
DUE TO
(c) | | | | INTERVAL BETWEEN ONSET AND DEATH
3 hrs
1 year | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from 3 Apr 19 62 to 3 Apr 19 62 that (I) (last) saw the deceased alive on 3 Apr 19 62 , and that death occurred at 440 P , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
John A Moore | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
3 APRIL 1962 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN A MOORE, Major USAF MC | | | | 22d. ADDRESS
USAF HOSP, ANDREWS AIR FORCE BASE, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
April 5, 1962 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL | | 23d. LOCATION (City, town, or county) (State)
ARLINGTON, VIRGINIA | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
W. W. CHAMBERS CO. | | | | ADDRESS
577 11th St SE Wash. D.C. | | 25a. REC'D BY REGISTRAR
DATE APR 6 '62 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | |



CERTIFICATE OF DEATH

DATE OF DEATH

27 November 1900

RESIDENTIAL ADDRESS

BEATRICE A. FLETCHER

THOMAS J. (MILITARY) SAKS AS 32

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04941

CERTIFICATE OF DEATH

04939

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton
c. LENGTH OF STAY IN 1b 66 Years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Clinton, Maryland. | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Pr. Gee's Co.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton, Maryland
d. STREET ADDRESS Clinton, Maryland.
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) WILLIAM | | First BERNARD | | Middle KING | | Last | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 26- 1879 | |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 | | IF UNDER 24 HRS.
Hours 0 Min. 0 | | 4. DATE OF DEATH April 17th 19 62 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Own | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Henry King | | | | 14. MOTHER'S MAIDEN NAME Adelaide White | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 4201 | | 17. INFORMANT Cora Murphy 338 - Raleigh St. S. E. Wash., Dc. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
4201 DUE TO CORONARY ARTERIOSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. GENERAL ARTERIOSCLEROSIS
(b) GENERAL ARTERIOSCLEROSIS
(c) GENERAL ARTERIOSCLEROSIS | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 HOUR
YEARS
YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from NOV 15 1961 to APR 17 1962 , that (I) (we) last saw the deceased alive on APR 17 1961 , and that death occurred at 11:25AM the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Paul Chen, M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED APRIL 17, 1962 | |
| 22c. PHYSICIAN'S NAME (Type) PAUL CHEN, M. D. | | | | 22d. ADDRESS ACCOKEEK, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF April-19-62 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City, town or county) (State) Suitland, Maryland. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Summers Brothers | | | | 1661 1/2 Good Hope Rd SE Washington DC. | | 25a. REC'D BY REGISTRAR APR 19 '62 25b. REGISTRAR'S SIGNATURE Arthur P. Jones | |

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Princess George's

Clinton

Clinton, Maryland

INDIAN

Male White

Married

Henry Lane



60 years

Clinton, Maryland

Clinton, Maryland

INDIAN

INDIAN

April 25 - 1978

Age

Married

Married

Abelardo White

Age

born January 29 - Reisterstown, Md.

CORONARY OCCLUSION

CHRONIC ARTERIOSCLEROSIS

CHRONIC ARTERIOSCLEROSIS

1 hour

years

years

NOV 12 01 APR 17 05

11:22AM

APR 17 01

APRIL 17, 1968

X

RECORDED, MD.

PAUL CHEN, M.D.

Clinton, Maryland

Clinton, Maryland

April 19-68

Married

1001-1002 Room 24 22
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04942

04940

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>
c. LENGTH OF STAY IN 1b <u>adm 7-17-56</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>LAUREL SANITARIUM</u> | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>—</u> ✓
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3301-4</u>
d. STREET ADDRESS <u>3303 N. CHARLES ST.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>SAPPY BRUCE Kinsolving</u>
First Middle Last
4. DATE OF DEATH <u>4</u> <u>27</u> <u>1962</u>
Month Day Year | | 5. SEX <u>Female</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-14-1876</u> 9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>THOMAS SEDDON BRUCE</u>
14. MOTHER'S MAIDEN NAME <u>MARY ANDERSON</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>unknown</u>
16. SOCIAL SECURITY NO. <u>—</u>
17. INFORMANT <u>Hosp. RECORDS LAUREL SANITARIUM</u> Address <u>—</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>42</u> <u>0.0</u> DUE TO <u>Cardiac fibrillation (433.1)</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>arteriosclerotic heart disease</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>undiagnosed pulmonary disease</u>
INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u>
<u>many yrs</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u> | | 21. I certify that (I) (this hospital) attended the deceased from <u>7-17-1956</u> to <u>4-27-62</u> ; that (I) (we) last saw the deceased alive on <u>4-27-1962</u> and that death occurred <u>7:55</u> A.M. from the causes and on the date stated above. | |
| 22a. SIGNATURE <u>Enbon P. Kraemer</u> M.D. 22b. DATE SIGNED <u>4-27-62</u>
22c. PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u> 22d. ADDRESS <u>LAUREL SANITARIUM LAUREL Md</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4-28-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas's Church</u> 23d. LOCATION (City, town or county) <u>Garrison, Maryland</u> (State) <u>—</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons</u> 25a. REC'D BY REGISTRAR <u>—</u> DATE <u>4-1-62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur J. Harris</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|---|--|
| 04943 | | Item 8 Film G312 5/11/62 mh | | 04941 | |
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY IN lb
24 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince Georges General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
66 Riverdale
d. STREET ADDRESS
6314 Patterson Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
Henry
First
Kumm
Middle
Last | | 4. DATE OF DEATH
Month
A pril
Day
26
Year
19 62 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
1893
9 Jan 1963 ? | | 9. AGE (In years last birthday)
69 yrs. | | IF UNDER 1 YEAR
Months
Days
Hours
Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CarpenterRetired | | 10b. KIND OF BUSINESS OR INDUSTRY
Self | | 11. BIRTHPLACE (County & State, or foreign country)
New York | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
August Kumm | | | |
| 14. MOTHER'S MAIDEN NAME
Elizabeth Essenburg | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
no | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Henry Kumm Jr.
Address
Same as #2 (son) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Garcimona of prostate
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Possible Right Pulmonary Metastasis
(c) Bone Metastasis Ilium Bone
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)
(County)
(State) | |
| 21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at....., 19....., from the causes and on the date stated above.
5.30A M | | | | | |
| 22a. SIGNATURE
Dr. L. Backrack, M.D. | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type)
Dr. L. Backrack., M.D. | |
| 22d. ADDRESS
915 19th St., N.W., Washington 6, D.C. | | 23a. REC'D BY REGISTRAR
DATE
MAY 1 '62 | | | |
| 23b. REGISTRAR'S SIGNATURE
Arthur S. Krum | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23d. LOCATION (City, town or county)
Colmar Manor, Md. | | 23e. DATE THEREOF
4/30 /62 | | | |
| 23f. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23g. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23h. LOCATION (City, town or county)
Colmar Manor, Md. | | 23i. DATE THEREOF
4/30 /62 | | | |
| 23j. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23k. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23l. LOCATION (City, town or county)
Colmar Manor, Md. | | 23m. DATE THEREOF
4/30 /62 | | | |
| 23n. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23o. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23p. LOCATION (City, town or county)
Colmar Manor, Md. | | 23q. DATE THEREOF
4/30 /62 | | | |
| 23r. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23s. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23t. LOCATION (City, town or county)
Colmar Manor, Md. | | 23u. DATE THEREOF
4/30 /62 | | | |
| 23v. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23w. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23x. LOCATION (City, town or county)
Colmar Manor, Md. | | 23y. DATE THEREOF
4/30 /62 | | | |
| 23z. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23aa. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23ab. LOCATION (City, town or county)
Colmar Manor, Md. | | 23ac. DATE THEREOF
4/30 /62 | | | |
| 23ad. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23ae. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23af. LOCATION (City, town or county)
Colmar Manor, Md. | | 23ag. DATE THEREOF
4/30 /62 | | | |
| 23ah. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23ai. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23aj. LOCATION (City, town or county)
Colmar Manor, Md. | | 23ak. DATE THEREOF
4/30 /62 | | | |
| 23al. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23am. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23an. LOCATION (City, town or county)
Colmar Manor, Md. | | 23ao. DATE THEREOF
4/30 /62 | | | |
| 23ap. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23aq. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23ar. LOCATION (City, town or county)
Colmar Manor, Md. | | 23as. DATE THEREOF
4/30 /62 | | | |
| 23at. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23au. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23av. LOCATION (City, town or county)
Colmar Manor, Md. | | 23aw. DATE THEREOF
4/30 /62 | | | |
| 23ax. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23ay. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23az. LOCATION (City, town or county)
Colmar Manor, Md. | | 23ba. DATE THEREOF
4/30 /62 | | | |
| 23ba. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bb. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bb. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bc. DATE THEREOF
4/30 /62 | | | |
| 23bc. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bd. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bd. LOCATION (City, town or county)
Colmar Manor, Md. | | 23be. DATE THEREOF
4/30 /62 | | | |
| 23be. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bf. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bf. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bg. DATE THEREOF
4/30 /62 | | | |
| 23bg. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bh. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bh. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bi. DATE THEREOF
4/30 /62 | | | |
| 23bi. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bj. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bj. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bk. DATE THEREOF
4/30 /62 | | | |
| 23bk. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bl. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bl. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bm. DATE THEREOF
4/30 /62 | | | |
| 23bm. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bn. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bn. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bo. DATE THEREOF
4/30 /62 | | | |
| 23bo. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bp. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bp. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bq. DATE THEREOF
4/30 /62 | | | |
| 23bq. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23br. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23br. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bs. DATE THEREOF
4/30 /62 | | | |
| 23bs. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bt. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bt. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
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Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
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Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
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Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
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Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
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Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
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Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
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Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
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Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
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4/30 /62 | | | |
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Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
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Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
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Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
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Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
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Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
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Colmar Manor, Md. | | 23bu. DATE THEREOF
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Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
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Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
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Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
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Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
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Ft. Lincoln | | | |
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4/30 /62 | | | |
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Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
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4/30 /62 | | | |
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4/30 /62 | | | |
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Ft. Lincoln | | | |
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Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
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Ft. Lincoln | | | |
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Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
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Colmar Manor, Md. | | 23bu. DATE THEREOF
4/30 /62 | | | |
| 23bu. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23bv. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | |
| 23bv. LOCATION (City, town or county)
< | | | | | |

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1993

CERTIFICATE OF DEATH

04944

04942

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges County
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY IN 1b
12 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince Georges General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince Georges County
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Beltsville
d. STREET ADDRESS
10678 Edmonston Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Walter
First Middle Last
Lampkin | | 4. DATE OF DEATH
Month Day Year
April 22, 1962 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-14-13 |
| 9. AGE (In years last birthday)
49 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machanic | | 10b. KIND OF BUSINESS OR INDUSTRY
W. S. S. C. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Charles Lampkin | | 14. MOTHER'S MAIDEN NAME
Callie Brown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
yes WW 11 | | 16. SOCIAL SECURITY NO.
232-18-3782 | |
| 17. INFORMANT
Clara M. Lampkin Same as #2 Wife | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) anemia
60000 DUE TO
Conditions, if any, which gave rise to immediate cause (b) chronic pyelonephritis
(a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
Hypertensive Cardio Vascular Disease | | INTERVAL BETWEEN ONSET AND DEATH
3 mos
2 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-10-1962 to 4-22-1962 , that (I) (we) last saw the deceased alive on April 22, 1962 , and that death occurred at 6:50 P.M. the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Norman Donat Comera | | 22b. DATE SIGNED
4/22/62 | |
| 22c. PHYSICIAN'S NAME (Type)
NORMAN DONAT COMERA | | 22d. ADDRESS
3503 PENNYST MT RAINIER MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/25/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City, town or county) (State)
Arlington, Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Lucas some Hyattsville, Md. | | 25a. REC'D BY REGISTRAR
DATE APR 25 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01915

CERTIFICATE OF BIRTH

01915

Birth of *Charles Hamilton*
on *11-19-1915*
at *St. Louis, Mo.*
Parents *John M. Hamilton* and *Elizabeth M. Hamilton*
Residence *St. Louis, Mo.*
U.S.A.
WW II
333-8-3182
John M. Hamilton born at St. Louis

Report of Birth
Charles Hamilton
11-19-1915
St. Louis, Mo.
John M. Hamilton
Elizabeth M. Hamilton
St. Louis, Mo.
U.S.A.
WW II
333-8-3182
John M. Hamilton born at St. Louis

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04945

04943

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY PRINCE GEORGES MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY PRINCE GEORGES | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CAMP SPRINGS | | | | c. LENGTH OF STAY IN 1b
47 DAYS | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X CAMP SPRINGS | | | | d. STREET ADDRESS
ANDREWS AFB MD (NAF) | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
USAF HOSPITAL ANDREWS | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First THOMAS Middle LEO Last LEONARD | | | | 4. DATE OF DEATH
Month APRIL Day 22 Year 1962 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
CAU | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
22 OCTOBER 1939 | |
| 9. AGE (In years last birthday)
22 yrs. | | IF UNDER 1 YEAR
Months 22 Days 22 Hours 22 Min. | | IF UNDER 24 HRS.
Months 22 Days 22 Hours 22 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SAILOR | | | | 10b. KIND OF BUSINESS OR INDUSTRY
US NAVY | | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME
RITA LEONARD | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
YES | | | | 16. SOCIAL SECURITY NO.
174-32-6225 | | 17. INFORMANT
JOSEPH F SPENCE, COUSIN, | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aplastic Anemia
292.4 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
47 days | | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6 Mar 19 62 , to 22 April 19 62 , that (I) (we) last saw the deceased alive on 22 April 19 62 , and that death occurred at 9:50 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Barry Ladd | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
22 April 62 | |
| 22c. PHYSICIAN'S NAME (Type)
BARRY LADD, CAPT, USAF, MC | | | | 22d. ADDRESS
USAF HOSPITAL, ANDREWS AFB MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Type)
BURIAL | | | | 23b. DATE THEREOF
4/24/62 | | 23c. NAME OF CEMETERY OR CREMATORY
NORWOOD PENNA | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
W.W. Chambers Co. Washington | | | | ADDRESS
1400 Chapin St. Washington | | REC'D BY REGISTRAR
APR 25 '62 | |
| 25a. REGISTRAR'S SIGNATURE
Arthur E. Ladd | | | | 25b. REGISTRAR'S SIGNATURE
Arthur E. Ladd | | | |

MEDICAL CERTIFICATION

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Page 4 may be obtained by the hospital or attending physician.

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CENTRE CASE OF DEATH

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TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, place 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04946

04944

| | | | | | |
|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY IN 1b
2 mos. 25 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince George's General Hospital | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
66 East Pines
d. STREET ADDRESS
6313 Riverdale Road
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
Clement John Lindsay | | | 4. DATE OF DEATH
Month Day Year
April 6 19 62 | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
10-5-90 | | 9. AGE (In years last birthday)
71 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Barber | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (State or foreign country)
New Jersey | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
George W. Lindsay | | | |
| 14. MOTHER'S MAIDEN NAME
Florence Turner | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | | |
| 16. SOCIAL SECURITY NO.
579-28-6083 | | 17. INFORMANT
Ralph E. Lee 5903 67th Ave. Riverdale, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PURULENT MENINGITIS
DUE TO (b) DECUBITI ULCERS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) FRACTURE RT FEMUR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
Pedestrian struck by an automobile | | | |
| 20c. TIME OF INJURY
Month, Day, Year
1:30 p.m. 12-9-61 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Street | |
| 20f. (City or town)
Riverdale P. 2. Md | | 20g. (County)
Prince George's | | 20h. (State)
Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
James I. Boyd
EXAMINER'S NAME (Type)
Dr. James I. Boyd | | M.D.
Dr. James I. Boyd | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
April 6, 1962 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
4/10/62 | | 22c. NAME OF CEMETERY OR CREMATORY
Congressional | |
| 22d. LOCATION (City, town, or country)
Washington D. C. | | 23. FUNERAL DIRECTOR
Francis Gasch's Sons | | 24a. REC'D BY REGISTRAR
DATE APR 12 '62 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Hanna | | 24c. ADDRESS
Hyattsville, Md. | | | |

(M)

(1)

George W. Lindsey

Washington D.C.

Washington D.C.

1952

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 04948 | | | | | | | | | | | |
| 04946 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY IN 1b
2 Hrs. 44 Mins.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince George's General Hospital | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Glen Arden
d. STREET ADDRESS
7919 Fiske Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Baby Girl (A)
First Middle Last
Louderman | | | | | | 4. DATE OF DEATH
Month Day Year
April 5 19 62 | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 5, 1962 | | 9. AGE (In years last birthday)
yrs. Months Days
2 44 | | IF UNDER 1 YEAR
IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Graham Lambert
<i>Louderman, Jr.</i> | | | | | | 14. MOTHER'S MAIDEN NAME
Ida Mae Woods | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mother | | Address
Same as above | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
77 6X DUE TO Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Pre-mature Labor
(b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 1/2 hr
5 hr | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour e.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-5 , 19 62 , to 4-5 , 19 62 that (I) (we) last saw the deceased alive on 4-5 , 19 62 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Henry A. Wise Jr.
M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
Henry A. Wise Jr. | | | | | | 22d. ADDRESS
9005 Volta St, Lanham, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE THEREOF
4-13-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Prince Geo. Gen. Hospital | | | | 23d. LOCATION (City, town or county) (State)
Cheverly, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Harry W. Penn, Jr.,
Administrator | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE APR 23 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hines | |

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CENTRAL OF MATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO VITAL RECORDS: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 04949 | | | | | | 04947 | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Prince George's | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | | c. LENGTH OF STAY IN 1b
2 Hrs. 42 Mins. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glen Arden | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | | | | | d. STREET ADDRESS
7919 Fiske Avenue | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Baby Boy (B) | | | | | | First Middle Last
Lounderman | | 4. DATE OF DEATH
Month Day Year
April 5 19 62 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 5, 1962 | | 9. AGE (In years last birthday)
yrs. | | IF UNDER 1 YEAR
Months Days
2 42 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Md. | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Graham Lambert | | | | | | 14. MOTHER'S MAIDEN NAME
Ida Mae Woods | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give year or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mother | | Address
Same as above | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
77 6X DUE TO Prematurity
Conditions, if any, which gave rise to immediate cause (b) DUE TO Pre-mature labor
(e), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 1/2 hrs
5 hr | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour e.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-5, 19.62 to 4-5, 1962, that (I) (we) last saw the deceased alive on 4-5, 19.62, and that death occurred at 8:30, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Henry A. Wise Jr. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
Henry A. Wise Jr. | | | | | | 22d. ADDRESS
9005 Volta St, Lanham, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | | | 23b. DATE THEREOF
4-13-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Prince Geo. Gen. Hospital | | 23d. LOCATION (City, town or county)
Cheverly, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Harry W. Penn, Jr., Administrator | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE APR 23 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

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13
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04950

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03641

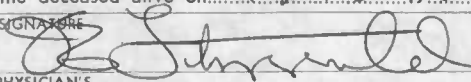
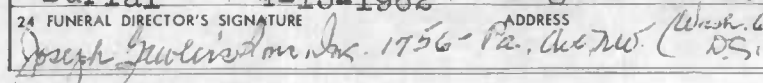
| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY | | Items 4, 8 & 22 Film 0311 4/16/62 wh | | USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE | | b. COUNTY | |
| Prince George's | | MARYLAND | | Maryland | | Chalres | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| Camp Springs | | DOA | | Waldorf | | CPX-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | M.C.A. Housing Apt 11 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| U. S. Airforce Hospital | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) | | First | | Last | | 4. DATE OF DEATH
Month Day Year | |
| Orsoline Marie Lowmiller | | | | | | April 3 19 62 | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| Female | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | July 24, 1926 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| House wife | | Own Home | | Kansas | | U. S. A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Virgilio Bonati | | Josephine | | UNKNOWN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| no | | | | Robert Eugene Lowmiller, same as # 2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) | | CEREBRAL HEMORRHAGE | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1911.3 DUE TO | | HYPERTENSION | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO | | | | | |
| | | TUMOR OF RIGHT ADRENAL GLAND | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| ACTUAL SIGNATURE | | DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | James I. Boyd | | April 3, 1962 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| BURIAL | | 4/6/62 | | Holy Cross Cemetery | | Harrisburg PA. | |
| 23. FUNERAL DIRECTOR | | ADDRESS | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| W.W. CHAMBERS CO. | | 5801 CLEVELAND AVE. | | APR 6 '62 | | Arthur S. Thomas | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. See pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7/61

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|--|--|--------------------------------------|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 04951 Item 2 Film 0311 1/17/62 04948 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville
c. LENGTH OF STAY IN 1b
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Carroll Manor | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington
d. STREET ADDRESS
1632 Primrose Rd. N.W.
4922 Lasalle Road
IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
VIRGINIA T. MAHAN | | | | 4. DATE OF DEATH
Month Day Year
April 10 1962 | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1-16-1896 | | 9. AGE (In years last birthday)
66 yrs. | | IF UNDER 1 YEAR
Months Days
66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
- - - - | | | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Robert Martin Thompson | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Rebecca Berry | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
- - - | | | | 16. SOCIAL SECURITY NO.
- - - | | | | 17. INFORMANT
Betty Jane Doyle
Address
5807 Wiltshire Dr. Washington, D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
154X DUE TO (b) Carcinoma rectum
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 mos
4 mos | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov , 19 58 , to Apr 10 , 19 62 ; that (I) (we) last saw the deceased alive on Apr 5 , 19 62 , and that death occurred at 3:30 PM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
 | | | | 22b. DATE SIGNED
Apr 19 1962 | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
J. E. Fitzgerald | | | | 22d. ADDRESS
Georgetown University Hospital Washington, D. C. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-13-1962 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l. Cemetery, Arlington, Va. | | | | 23d. LOCATION (City, town or county) (State)
(State) | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
 | | | | ADDRESS
1756-12, Ave NW (Wash. D.C.) | | | | 25a. REC'D BY REGISTRAR
DATE APR 12 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

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FOR STATE
HEALTH DEPT. **M**
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

04953 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04950

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 48 Mount Rainier | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | d. STREET ADDRESS 4308 Russell Avenue | |
| 3. NAME OF DECEASED (Type or print) Agnes Irene McAllister | | 4. DATE OF DEATH April 11, 1962 | |
| 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 5, 1889 | |
| 9. AGE (In years last birthday) 72 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Henry Taylor | | 14. MOTHER'S MAIDEN NAME Sarah Elizabeth Wells | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT 4849 ^{ess} Queens Chapel Terr | | Joseph Henry McAllister Jr. D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute congestive heart failure
4-2000 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO
(b) Arteriosclerotic heart disease
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes, obesity | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE James I. Boyd | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) JAMES I. BOYD, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 14, 1963 | |
| 22c. NAME OF CEMETERY OR CREMATORY Ford Leucalus | | 22d. LOCATION (City, town, or country) (State) Bladensburg, Md. | |
| 23. FUNERAL DIRECTOR Neal Funeral Home | | 24a. REC'D BY REGISTRAR DATE APR 16 '62 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna | | | |

04350

04350



Handwritten text, possibly a signature or address, located at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04954

04951

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>PRINCE GEORGE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/>
o. STATE <u>DC</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X.3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>MADISON MONOR NURSING HOME</u> | | | | d. STREET ADDRESS <u>4330 Valley Terrace St</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>REX</u> <u>McHoney</u> | | | | 4. DATE OF DEATH Month Day Year <u>April 28, 1962</u> | | | |
| 5. SEX <u>M.</u> | | 6. COLOR OR RACE <u>W.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7-30-1889</u> 72 yrs. | |
| 9. AGE (In years last birthday) <u>72</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | |
| 13. FATHER'S NAME <u>Christopher McHoney</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Levin Maxey</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>322-10-0635</u> | | 17. INFORMANT Address <u>Glenda B. McClenning Washington DC</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Congestive Heart Failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u>
DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>April 28, 1962</u> that (I) (we) lost saw the deceased alive on <u>4-27-1962</u> and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Bernard Katzen</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>4-28-62</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>BERNARD KATZEN</u> | | | | 22d. ADDRESS <u>3550 - Main - Ave - S -</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>5-4-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Hollywood</u> | | 23d. LOCATION (City, town, or county) (State) <u>Hollywood MD</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. LEB</u> ADDRESS <u>3004 1st NE</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>MAY 3 '62</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | | | |
|--|------------------------------|--|---|--|--|
| 04955 | | Item 7 Film 311 4/13/62 ink | | 04952 | |
| 1. PLACE OF DEATH
a. COUNTY <u>PRINCE GEORGES</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hyattsville</u>
c. LENGTH OF STAY IN 1b <u>1 week</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PAINT BRANCH NURSING HOME</u> | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE <u>Md.</u>
b. COUNTY <u>PRINCE GEORGES</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berwyn Heights 68</u>
d. STREET ADDRESS <u>8521 58 Ave</u> | | a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Elizabeth</u> Middle <u>A.</u> Last <u>McNamara</u> | | 4. DATE OF DEATH
Month <u>April</u> Day <u>4</u> Year <u>1962</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>Cauc</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
B. <u>2-28-1884</u> | | 9. AGE (In years last birthday) <u>78</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Specialty Shop</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>New York City</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | | 13. FATHER'S NAME <u>Thomas McNamara</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret McALEER</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>076-10-2301</u> | | 17. INFORMANT <u>ANNA W. McNamara</u> Address <u>SAME AS #2 above</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized abdominal Carcinomatous</u>
<u>165X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>= Metastasis to lungs</u>
(c) | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 6</u> 19 <u>62</u> to <u>April 4</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/19</u> 19 <u>62</u> , and that death occurred at <u>8:30 AM</u> from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>W.C. Etienne</u> | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>W.C. ETIENNE</u> | | 22d. ADDRESS <u>College Park, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Apr 9, 1962</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St Charles Cemetery</u> | |
| 23d. LOCATION (City, town or county) (State) <u>Freeport New York</u> | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> | | ADDRESS <u>Hyattsville, Md.</u> | | 25a. REC'D BY REGISTRAR <u>APR 6 '62</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | |
| 04956 | | | | | | 04953 | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | Information from birth cert. | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George's</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>
c. LENGTH OF STAY IN TB
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>45 Brentwood</u>
d. STREET ADDRESS <u>4014 Webster ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>BABY BOY MICKLE</u> | | | | | | 4. DATE OF DEATH <u>4-22</u> 19 <u>62</u> | | | | | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>C</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-18-62</u> | | 9. AGE (In years last birthday) <u>—</u> yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME <u>Willie James Mickle</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>MARIAN T. Lewis</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ATELECTASIA</u>
<u>762.5</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>PREMATURITY</u>
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>LIFE</u>
<u>LIFE</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-18</u> 19 <u>62</u> to <u>4-22</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4-22</u> 19 <u>62</u> and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>S.V. Battiatia M.D.</u> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>4/23/62</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>S.V. BATTIATA M.D.</u> | | | | | | 22d. ADDRESS <u>7309 RIGGS RD HYATTSVILLE MD.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town or county) (State) | | | | | | | |
| <u>Burial</u> | | <u>4/21/1962</u> | | <u>Mt. Olivet</u> | | <u>Washington, D.C.</u> | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Fisher</u> | | | | | | ADDRESS <u>W. Ernest Jarvis Co., Inc. 1432 You Street, N.W.</u> | | 25a. REC'D BY REGISTRAR <u>APR 25 '62</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u> | | | |

2-046508



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04955

04954

| | | | |
|---|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Southern Maryland</u> | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>pr geor</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CLINTON, MD</u>
d. STREET ADDRESS <u>1st 1, Box 649-</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>Martha Irene Miller</u> | | 4. DATE OF DEATH Month Day Year
<u>April 4 1962</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-July 1902</u> |
| 9. AGE (In years last birthday) <u>59</u> yrs. | | IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | |
| 11. BIRTH PLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John A. Rahey</u> | | 14. MOTHER'S MAIDEN NAME <u>Olivia Garner</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Harry J. Miller Same #2</u> | |
| 17. INFORMANT <u>Harry J. Miller</u> | | Address <u>Same #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
420-1 DUE TO <u>Cardiovascular Disease</u>
Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis, generalized</u>
(c) <u>Diabetes mellitus</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 hours</u>
<u>44 days</u>
<u>2 1/2 yrs</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 1957</u> to <u>April 4, 1962</u> that (I) (we) last saw the deceased alive on <u>4/4/62</u> 19 <u>62</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Alfred R. Lapin</u> M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN</u> | | 22d. ADDRESS <u>CLINTON, MARYLAND</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial April 7-62</u> | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>St John Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Clinton Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Sammons Bros</u> | | 25a. REC'D BY REGISTRAR <u>1661-94 Hopedale SE</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | | DATE <u>APR 6 '62</u> | |

(M)

Clinton

From wife

Yonkers

John R. Rockefeller

To

Government

Clinton

Yonkers

Clinton

Yonkers

Clinton

Yonkers

Clinton

Yonkers

Clinton

Yonkers

After R. R. R. Clinton, N. Y.

Clinton, N. Y.

Clinton, N. Y.

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FOR STATE
HEALTH DEPT. (M)
76
1
DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04958
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
04955

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|----------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale | | | | c. LENGTH OF STAY IN 1b 10 min. | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Colmar Manor | | | | | |
| 3. NAME OF DECEASED (Type or print) EMMA Schlorb MOCKABEE | | | | d. STREET ADDRESS 3406 43rd Ave. | | | | | |
| 5. SEX Female | | | | 4. DATE OF DEATH April 14 1962 | | | | | |
| 6. COLOR OR RACE White | | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | |
| 8. DATE OF BIRTH October 2, 1895 | | | | 9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME George L. Schlorb | | | | 14. MOTHER'S MAIDEN NAME Mary Ellen Donaldson | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 722-05-0339 | | | | | |
| 17. INFORMANT Paul Francis Mockabee | | | | Address Randolph Village MD 9100 Central Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 442X Acute congestive heart failure
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease
(a), stating the underlying cause last. DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause xxx Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE James I. Boyd | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) JAMES I. BOYD | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | DATE SIGNED 4/14/62 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 4-17-1962 | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Addison Chapel | | | | 22d. LOCATION (City, town, or country) (State) Seat Pleasant, Md | | | | | |
| 23. FUNERAL DIRECTOR W. W. Chambers Co Riverdale, Md | | | | 24a. REC'D BY REGISTRAR APR 17 '62 | | | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Harris | | | | | |

Prince George's

Maryland

Prince George's

Colony Manor

10 min.

Riverdale

3400 4th Ave.

Ireland Memorial Hospital

April 18

MOONSHINE

Shelby

EMMA

October 2, 1955

x

White

Female

USA

Maryland

Home

Honolulu

Mary Ellen Harrison

George I. Bonford

Handson Village

Paul Francis Harrison 3100 Central Ave.

He

Acute congestive heart failure

Cardiovascular renal disease

Diabetes

x

x

xxx

4/2/55

June 1, 1955

[Handwritten notes and signatures at the bottom of the page, including "George I. Bonford" and "Paul Francis Harrison"]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04959 CERTIFICATE OF DEATH 04956

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges County
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY in 1b
1 Day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince Georges General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince Georges
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
College Park
d. STREET ADDRESS
9314 - 49th. Ave.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Icy Delphia Moore | | 4. DATE OF DEATH
Month Day Year
April 14, 1962 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-5-74 |
| 9. AGE (In years last birthday)
87 yrs. | | 10. IF UNDER 1 YEAR
Months Days | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Domestic | |
| 11. BIRTHPLACE (County & State, or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Robert W. Moore | | Address
1322-V-St., S. E. Wash. DC | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
Chronic Congestive Heart Failure
DUE TO (c)
Arterio-sclerotic Cardio-vascular disease | | INTERVAL BETWEEN ONSET AND DEATH
2 days 5 p.m. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 4-13-1962 to 4-14-1962 that (I) (we) last saw the deceased alive on April 14, 1962 , and that death occurred at 9:30 P.M. the causes and on the date stated above. | | | |
| 22a. SIGNATURE
W. L. Etienne
M.D. | | 22b. DATE
4/15/62 | |
| 22c. PHYSICIAN'S NAME (Type)
W. L. Etienne | | 22d. ADDRESS
College Park Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
April 18-62 | 23c. NAME OF CEMETERY OR CREMATORY
East Hill Cemetery | 23d. LOCATION (City, town or county) (State)
Salem Va. |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Samuel Bro. | | 25a. REC'D BY REGISTRAR
1661 - North Hope Rd SE
WASH. 20 D.C. | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Hume | | DATE
APR 23 '62 | |

(M)

01959

CERTIFICATE OF DEATH

01959

United States County

State of New York

City

I, my

College and

United States General Hospital

State of New York

Sex

Marital

Age

Weight

52

Height

Color

X

12-2-71

63

Hospital

County

State of New York

USA

Signature

Signature

Robert M. Moore

12-2-71

Handwritten notes and signatures in the lower section of the form.

65

11-13

1-11-69

1-11-69

Extensive handwritten notes and signatures at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04960

04957

| | | | |
|---|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY in 1b
3 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince Georges General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince Georges County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Capital Heights
d. STREET ADDRESS
304 - 48th. Ave.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Edna
MARTHA
Murphy | | 4. DATE OF DEATH
Month April Day 25 Year 19 62 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-19-95 |
| 9. AGE (In years last birthday)
67 yrs. | | 10. IF UNDER 1 YEAR
Months 6 Days 17 Hours 15 Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SUPT. G.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
ALEXANDER HUMES | | 14. MOTHER'S MAIDEN NAME
JESSIE FLETCHER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
NO | | 16. SOCIAL SECURITY NO.
577-03-5443 | |
| 17. INFORMANT
JOHN D. MURPHY | | 18. ADDRESS
6508 MARLBORO PIKE WASH. 28 D.C. (SON) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Brain Tumor
237X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) Bilateral Pulmonary Edema
(c) Arteriosclerotic Heart Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour 19 e.m. p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 22, 1962 to April 25, 1962 that (I) (we) last saw the deceased alive on April 25, 1962 , and that death occurred at 11:00 P.M. on the date stated above. | | | |
| 22a. SIGNATURE
Hei K. Lee | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Hei Kit Lee | | 22d. ADDRESS
7730 Annapolis Rd., Lanham, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/30/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL | | 23d. LOCATION (City, town or county) (State)
ARLINGTON VA. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
W.W. Chambers Co. | | 25a. REC'D BY REGISTRAR
DATE MAY 2 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur L. Thomas | | | |

01950

CERTIFICATE OF DATA

1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY in b
7 Hrs. 7 Mins.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Landover
d. STREET ADDRESS
569 Hill Road, Huntville
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Baby Girl | | 4. DATE OF DEATH
Month April Day 24 Year 19 62 | |
| 5. SEX
Female | | 6. COLOR OR RACE
Colored | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 24, 1962 | |
| 9. AGE (In years last birthday)
yrs. | | 10. IF UNDER 1 YEAR
Months Days
7 7 | |
| 11. BIRTHPLACE (County & State, or foreign country)
Prince George's, Md. | | 12. CITIZEN OF WHAT COUNTRY?
Same as above | |
| 13. FATHER'S NAME
James Harold Newman | | 14. MOTHER'S MAIDEN NAME
Irene Cecelia Robinson Newman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO.
Mother | |
| 17. INFORMANT
Mother | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac temponade
DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. }
(b) Atelectasis of left lung
DUE TO
(c) Hemothorax left side | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
Life
Life
Life | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. p.m.
19 | | 20d. INJURY OCCURED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-24 to 4-24 , 19 62 , that (I) (we) last saw the deceased alive on 4-24 , 19 62 , and that death occurred at 12:20 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. Joseph J. McDonald | | 22b. DATE SIGNED
4/26/62 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Joseph J. McDonald | | 22d. ADDRESS
7309 Riggs Rd., W. Hyattsville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE THEREOF
May 5, 1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Prince Geo. Gen. Hospital | | 23d. LOCATION (City, town or county) (State)
Cheverly, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Harry W. Penn, Jr., Administrator | | 25a. REC'D BY REGISTRAR
DATE MAY 8 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Charles S. Thomas | | | |

8000

100

(M)

(C)

(S)

George's, Virginia

George's, Virginia

George's, Virginia

George's, Virginia

George's, Virginia

George's, Virginia

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George's, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

04952

CERTIFICATE OF DEATH

Reg. Dist. No. 04959

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> | | c. LENGTH OF STAY IN 1b <u>1 yr.</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> | | 4b. <u>46</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3717-Shepherd St.</u> | | d. STREET ADDRESS <u>3717-Shepherd St.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Patricia Ann Nuzzo</u> | | 4. DATE OF DEATH <u>4-30-1962</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> | | 8. DATE OF BIRTH <u>Oct. 28, 1905</u> | |
| 9. AGE (In years lost birthday) <u>56</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Government Treasury Dept.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>St. Thomas Virgin Isl. U.S.A.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Frank Duurloo</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Vaughan</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>101-445-3544</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u>
175.0 DUE TO (b) <u>Carcinoma of Ovary</u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (c) <u>Congestive heart failure</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ascites and Pleural effusion</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1960</u> , 19 <u>62</u> , to <u>4/29</u> , 19 <u>62</u> that I last saw the deceased alive on <u>4/29</u> , 19 <u>62</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <u>2802 - Heller. Road Silver Spring, Md.</u> | |
| ACTUAL SIGNATURE <u>MARINO SORVILL</u> M.D. | | DATE SIGNED <u>4-30-1962</u> | |
| PHYSICIAN'S NAME (Type) <u>Marino Sorvill</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/2/62</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u> | | 22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u> | | 24a. REC'D BY REGISTRAR <u>May 3 '62</u> | |
| ADDRESS <u>Mt. Rainier Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04963

CERTIFICATE OF DEATH

04960

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>
c. LENGTH OF STAY IN 1b <u>8 mo</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____ | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u> 40
d. STREET ADDRESS <u>4000-53 ave ST 1</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>AMOS CHARLES OGBURN</u>
First Middle Last | | 4. DATE OF DEATH <u>April 5</u> 19 <u>62</u>
Month Day Year | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov 7 1874</u>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> yrs. Months Days Hours Min. | 9. AGE (In years last birthday) <u>87</u>
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Pine Village Ind., USA</u> | |
| 13. FATHER'S NAME <u>Charles William Ogburn</u> | | 14. MOTHER'S MAIDEN NAME <u>Shipman</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>Mr Roy Ogburn</u> Address <u>4000 53 St Bladensburg Md</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Exhaustion</u>
331X DUE TO <u>Cerebral hemorrhage</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Arterio Sclerosis</u>
(b) (c)
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
<u>4 days</u>
<u>years</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u> | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____ | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____; that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Dayton O Watkins</u> M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>4-5-62</u> | 22b. DATE SIGNED |
| 22c. PHYSICIAN'S NAME (Type) <u>DAYTON OWATKINS</u> | | 22d. ADDRESS <u>5318 annapolis rd Bladensburg Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>4/8/1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mummasburg Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Franklin Twp. Adams Co. Pa.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Matthew Bender</u> | | 25a. REC'D BY REGISTRAR <u>APR 9 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u> | |

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STATE OF TEXAS

5385

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04964

04961

| | | | | | | | |
|--|--|-----------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE D. C. b. COUNTY - | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital | | | | d. STREET ADDRESS 1827 Concoran St., N.W. | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Joseph C. - O'Neill, Sr. | | | | 4. DATE OF DEATH Month Day Year 4 23 19 62 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11/28/09 | |
| 9. AGE (In years last birthday) 52 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | | 11. BIRTHPLACE (County & State, or foreign country) Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Charles O'Neill | | | |
| 14. MOTHER'S MAIDEN NAME Esther Charashaw | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | |
| 16. SOCIAL SECURITY NO. Unknown | | | | 17. INFORMANT Decedent Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the larynx with metastases
161X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left radical neck dissection, 6/61 | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs., | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | 21. I certify that (I) (this hospital) attended the deceased from 1/12/1962, to 4/23/1962, that (I) (we) last saw the deceased alive on 4/23/1962, and that death occurred at P.M. from the causes and on the date stated above. | |
| 22a. SIGNATURE Moe Weiss | | | | | | 22b. DATE SIGNED 4/23/1962 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | | | | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | 23b. DATE THEREOF 4/27/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | | | | 23d. LOCATION (City, town or county) Suitland, Maryland (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Duppore | | | | | | 25a. REC'D BY REGISTRAR APR 30 '62 | |
| 25b. REGISTRAR'S SIGNATURE Arthur L. Hane | | | | | | | |

1934

DEPARTMENT OF HEALTH

1934

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See Also

Report of the Secretary of the Department of Health, Maryland, for the year 1934.
Baltimore, Maryland: Department of Health, 1935.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04965

CERTIFICATE OF DEATH

04962

| | | | | | |
|--|---|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE D.C. b. COUNTY ✓ | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Glenn Dale (rural) | | c. LENGTH OF STAY IN 1b
6 months and 16 days | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Washington 47X-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Glenn Dale Hospital | | | d. STREET ADDRESS
824 Buchanan St., N.E. | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Elizabeth - Parker | | | 4. DATE OF DEATH
Month Day Year
4 1 19 62 | | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1/6/1886 | 9. AGE (In years last birthday)
76 yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
- | 11. BIRTHPLACE (County & State, or foreign country)
Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Peter Scott | | | 14. MOTHER'S MAIDEN NAME
Emma Scott | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | 17. INFORMANT
Elizabeth Parker (daughter) address unknown | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Arteriosclerotic heart disease
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
Pulmonary tuberculosis | | | | | INTERVAL BETWEEN ONSET AND DEATH
15 min.
unknown |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/16/62 to 4/1/62, that (I) (we) last saw the deceased alive on 4/1/62, and that death occurred at A.M. from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Moe Weiss | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
4/1/62 |
| 22c. PHYSICIAN'S NAME (Type)
Moe Weiss, M.D. | | | 22d. ADDRESS
Glenn Dale Hospital
Glenn Dale, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
April 4, 1962 | 23c. NAME OF CEMETERY OR CREMATORY
Johnson Funeral Home | 23d. LOCATION (City, town or county) (State)
Franklin, Virginia | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
ALEXANDER S. POPE FUNERAL DIRECTORS | | | 25a. REC'D BY REGISTRAR
APR 6 '62
25b. REGISTRAR'S SIGNATURE
Arthur S. Hume | | |

01002

01002

(M)

(T)

Handwritten signature or mark.

MINISTRE, VICTORIA

April 4, 1968 Johnson

1968

Handwritten notes and stamps at the bottom of the page.

04966

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04963

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| | | | |
|--|------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN b DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE Maryland
f. COUNTY Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 4003 Queensbury Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Elizabeth Middle Agnes Last Payne | | 4. DATE OF DEATH
Month April Day 21 Year 19 62 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 8, 1903 |
| 9. AGE (In years last birthday) 58 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant | | 10b. KIND OF BUSINESS OR INDUSTRY Delicatessen | 11. BIRTHPLACE (State or foreign country) West Virginia |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME UNKNOWN Welty | |
| 14. MOTHER'S MAIDEN NAME Jennie Crim | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | |
| 16. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT Betty Jane Knight, Hyattsville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intracerebral Hemorrhage
331X DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE James I. Boyd | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) James I. Boyd | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED April 21, 1962 | |
| Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 4-25-1962 | |
| 22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM | | 22d. LOCATION (City, town, or county) (State) BLADENSBURG, MARYLAND | |
| 23. FUNERAL DIRECTOR W.W. Chambers Co Riverdale, Maryland | | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE | |
| DATE APR 24 '62 | | | |

(M)

Interpretation of Hemorrhage

Unusually

Unusually

Unusually

Unusually

Unusually

Unusually

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04967

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04964

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY IN lb
3 mos. 11 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Upper Marlboro
d. STREET ADDRESS
Box 101
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Mary Middle L. Last Payton | | 4. DATE OF DEATH
Month April Day 26 Year 1962 | |
| 5. SEX
Female | 6. COLOR OR RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-10-16 1917 |
| 9. AGE (In years last birthday)
45 yrs. | | 10. IF UNDER 1 YEAR
Months 2 Days 0 | 11. IF UNDER 24 HRS.
Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11. BIRTHPLACE (State or foreign country)
Washington, D.C. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
William Scrivner | |
| 14. MOTHER'S MAIDEN NAME
Elizabeth | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO.
No | | 17. INFORMANT
Mary Jackson Address Upper Marlboro, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli
916.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) 2nd. & 3rd. degree burns of 35% of body area
DUE TO (c) 3 1/2 months | | | INTERVAL BETWEEN ONSET AND DEATH
2 weeks |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Conflagration in the home | |
| 20c. TIME OF INJURY
Hour 2:00 p.m. Month, Day, Year January 15, 62 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | 20f. (City or town) (County) (State)
Marlboro, Prince Georges, Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>Dr. Paul C. Van Natta</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Dr. Paul C. Van Natta | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Address (Street, city, town, or county)
Highland Park Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
5-2-62 | 22c. NAME OF CEMETERY OR CREMATORY
Harmony | 22d. LOCATION (City, town, or country) (State)
Highland Park Md. |
| 23. FUNERAL DIRECTOR
Myrtle K. Rollins | | 24. REC'D BY REGISTRAR
4339 Hunt Pl. N.E. | |
| 25. REGISTRAR'S SIGNATURE
<i>Arthur S. Hanna</i> | | DATE
MAY 2 '62 | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04968

CERTIFICATE OF DEATH

04965

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
e. COUNTY Prince Geo. MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mitchellville
c. LENGTH OF STAY IN 1b 50 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince Geo.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mitchellville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
NORA Nelson Peach. | | | | 4. DATE OF DEATH Month Day Year
April 18 1962 | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 13, 1882 | | 9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (County & State, or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Robert Jones Nelson | | | | 14. MOTHER'S MAIDEN NAME
Anne Rebecca Englar | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Preston Peach | | Address
Same as # 2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Cachexia
151X DUE TO Adeno Carcinoma of Stomach
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 mos
6 mos. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from... Oct 16, 1962 to... 18 Apr 1962, that (I) (we) last saw the deceased alive on... 14 Apr 1962, and that death occurred at 2:40 PM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE R.B. Sasscer M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) R. B. Sasscer | | | | 22d. ADDRESS Marlboro, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 21 April 1962 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Oak Cem. | | 23d. LOCATION (City, town or county) (State) Mitchellville, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Gasch Funeral Home | | | | ADDRESS Hyatt, Md. 4739 Baltimore Av. | | 25a. REC'D BY REGISTRAR APR 24 '62 | | 25b. REGISTRAR'S SIGNATURE | |

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TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 1/62

04959

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04966

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Kent Village | | | |
| c. LENGTH OF STAY IN 1b D.O.A. | | | | d. STREET ADDRESS 7220 Euclid St. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last Albert William Peters | | | | 4. DATE OF DEATH
Month Day Year April 12, 1962 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 22, 1920 | |
| 9. AGE (In years last birthday) 42 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard helper | | 10b. KIND OF BUSINESS OR INDUSTRY B&O RR | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Phillip Fulmer Peters | | | | 14. MOTHER'S MAIDEN NAME Florence May Kirkland | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 11 | | | | 16. SOCIAL SECURITY NO. 210077008 | | | |
| 17. INFORMANT Thelma Dotson Peters, same as # 2 | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
420.1 DUE TO (b) CORONARY ARTERY OCCLUSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) HEMORRHAGE OF ATHEROMATOUS PLAQUE | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE James I. Boyd | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 4/12/62 | |
| EXAMINER'S NAME (Type) JAMES I. BOYD, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| Address (Street, city, town, or county) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 4-16-1962 | | 22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM | | 22d. LOCATION (City, town, or country) (State) BLADENSBURG, MARYLAND | |
| 23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md | | | | ADDRESS | | 24a. REC'D BY REGISTRAR APR 17 '62 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna | | | |

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Prince George's College

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|------------------------|---|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville | |
| c. LENGTH OF STAY in lb 55 minutes | | d. STREET ADDRESS 5116 Flintridge Dr. | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Baby Boy Peters | | 4. DATE OF DEATH April 26 1962 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 26, 1962 |
| 9. AGE (In years last birthday) yrs. 76 1/5 | | IF UNDER 1 YEAR Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Gordon A. Peters | | 14. MOTHER'S MAIDEN NAME Ruth Virginia Baker | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Address | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity (5 min pregnancy)
76 1/5 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Chronic hypertension of menopause
(c) DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Umbilical cord tight around neck
INTERVAL BETWEEN ONSET AND DEATH 12 hr | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-26 1962, to 4-26 1962, that (I) (we) last saw the deceased alive on 4/26 1962, and that death occurred 9:30 p.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John Kehoe | | 22b. DATE SIGNED 5-2-62 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. John Kehoe | | 22d. ADDRESS 6300 Riverdale Rd., Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF 5/5/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital | | 23d. LOCATION (City, town or county) (State) Cheverly, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator | | 25a. REC'D BY REGISTRAR MAY 8 '62 | |
| | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

2-046688

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Harry W. Pomeroy, Jr., President

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04971

CERTIFICATE OF DEATH

04968

| | | | | | | | |
|--|---------------------------|---|----------------------------------|--|--------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Adelphi Cheverly | | c. LENGTH OF STAY IN 1b
3 Hr | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
73 Adelphi | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George General Hospital | | | | d. STREET ADDRESS
1 2515 Buck Lodge Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Alice P. Powell | | | | 4. DATE OF DEATH
Month Day Year
A pr. 22 19 62 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 5, 1888 | 9. AGE (In years last birthday)
73 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (County & State, or foreign country)
Brooklyn N.Y. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
Carlton Frankard | | | | 14. MOTHER'S MAIDEN NAME
Martha C Marshall | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-44-2699 | | 17. INFORMANT Address
Marshall Powell Adelphi, Md. (Son) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Pulmonary Embolism
420.1 DUE TO Congestive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Myocardial Fibrosis
(c) DUE TO Coronary Arteriosclerotic Heart Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that (II) (this hospital) attended the deceased from 21 March 1960 to 4-22-62, that (II) (we) last saw the deceased alive on 4-22-62, and that death occurred at 4:45 PM, from the causes and on the date stated above.
22a. SIGNATURE R.D. Bauer, M.D.
22b. DATE SIGNED 4-22-62
22c. PHYSICIAN'S NAME (Type) R.D. Bauer, M.D.
22d. ADDRESS 2513 Buck Lodge Road, Adelphi, Md.
2513 Buck Lodge Rd. Adelphi, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Apr. 24 1962 | | 23c. NAME OF CEMETERY OR CREMATORY
Oakwood Cemetery | | 23d. LOCATION (City, town or county) (State)
Falls Church, Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Pearson Funeral Home Falls Church, Va. | | | | 25a. REC'D BY REGISTRAR
DATE APR 25 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kline | |

04108

CHARTER OF OATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04972

CERTIFICATE OF DEATH

04969

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George's</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>
c. LENGTH OF STAY IN 1b <u>2 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>
d. STREET ADDRESS <u>02X-2</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Lewis</u> Middle <u>H</u> Last <u>Priset</u> | | 4. DATE OF DEATH
Month <u>4</u> Day <u>29</u> Year <u>1962</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8-18-1885</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR
Months <u>7</u> Days <u>6</u> | IF UNDER 24 HRS.
Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Empldyd Blacksmith</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>State Roads Comm.</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>Wellsboro, Pa.</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | 13. FATHER'S NAME
<u>John Priset</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Rebecca Shaffer</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>--</u> | |
| 16. SOCIAL SECURITY NO.
<u>--</u> | | 17. INFORMANT Address
<u>Mrs. Margaret Cox-----Lothian, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u>
<u>526X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Lung Disease (Bronchectasis)</u>
(e), stating the underlying cause last. DUE TO (c) <u>27 yrs</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
<u>Hypertensive Cardiovascular Disease with Failure</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour <u>19</u> e.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-26</u> , 19 <u>62</u> to <u>4-29</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased elive on <u>4-29</u> , 19 <u>62</u> ; end that death occurred at <u>11:05 AM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Waldo B. Moyer</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED
<u>4-29-62</u> |
| 22c. PHYSICIAN'S NAME (Type)
<u>Waldo B. Moyer</u> | | 22d. ADDRESS
<u>3503 Perry St. Mt. Rainier Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>5/4/62</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Wellsboro Cemetery</u> | 23d. LOCATION (City, town or county) (State)
<u>Wellsboro, Penna.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Ritchie Bros. Fun'l Home-Upper Marlboro, Md.</u> | | 25a. REC'D BY REGISTRAR
<u>MAY 7 '62</u> | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hines</u> |

1945

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1
FOR STATE
HEALTH DEPT.

04973

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04970

| | | | |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Riverdale
c. LENGTH OF STAY IN b
D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Leland Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
Distric of Columbia
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Washington
d. STREET ADDRESS
300 Gallatin St., N.W.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Andrew Leo Radcliffe | | 4. DATE OF DEATH
April 29, 1962 | |
| 5. SEX
Male | 6. COLOR OR RACE
Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 10, 1904 |
| 9. AGE (In years last birthday)
58 | | 10. IF UNDER 1 YEAR
Months 58 Days 58 Hours 58 Min. 58 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Monocaster (Retired) | | 12. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. District of Columbia | |
| 13. FATHER'S NAME
Jesse Radcliffe | | 14. MOTHER'S MAIDEN NAME
Fannie Jackson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Florence Jackson Radcliffe, 119 You St. N.E. | | Address Washington, D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LACERATIONS, SPINAL CORD
812X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FRACTURED CERVICAL VERTEBRAE
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Struck by car while walking on Boulevard | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Struck by car while walking on Boulevard | |
| 20c. TIME OF INJURY
Month, Day, Year
10:45 p.m. 4/29 1962 | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
U.S. Rte. #1 | | 20f. (City or town) (County) (State)
Murkirk P.G. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Paul C. Van Natta | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
PAUL C. VAN NATTA, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
4/30/62 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
5.4.62 | |
| 22c. NAME OF CEMETERY OR CREMATORY
MT. OLIVET CEMETERY | | 22d. LOCATION (City, town, or country) (State)
WASHINGTON, D.C. | |
| 23. FUNERAL DIRECTOR
Edmond J. Smith | | 24a. REC'D BY REGISTRAR
1870-9th Wash. D.C. Ave | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | DATE
MAY 3 '62 | |

(M)

Prince George's

Riverdale

D.O.A.

Washington

Johns Memorial Hospital

300 Calverton St., N.W.

Andrew Leo

Baltimore

April 29

62

Male Colored

Feb. 10, 1904

Moonbeam (alias) U.S. Gov't. District of Columbia

U.S.A.

Fannie Jackson

Leeds Baltimore

Washington, D.C.

Unknown Florence Jackson Baltimore, Md.

LACERATIONS, 2 INCHES LONG

FRONTAL CEREBRAL VESSEL

Struck by car while walking on Boulevard

10:15 AM 1922 X U.S.A. 1 MURKIN

MA

7.3

X

X

PAUL J. VAN HATTEN, D.D.

ST. OLIVET CEMETERY WASHINGTON, D.C.

WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
04974
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04971

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Avondale | | c. LENGTH OF STAY IN 1b
14 Yrs. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Avondale 49 | | d. STREET ADDRESS
2025 Woodreeve Road | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
2025 Woodreeve Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle LESTER Last RICHARDS | | 4. DATE OF DEATH
Month April Day 11 Year 19 62 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
31 Oct. 1867 |
| 9. AGE (In years last birthday)
94 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. Conductor | | 10b. KIND OF BUSINESS OR INDUSTRY
B. & O. R. R. | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
UNK. | | 14. MOTHER'S MAIDEN NAME
UNK. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Type, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
705100060 | |
| 17. INFORMANT
Mrs. Billie J. Cain | | Address
Same as # 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GANGRENE OF FEET
450.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS
DUE TO
(c) 20 YRS. (?) | | INTERVAL BETWEEN ONSET AND DEATH
15 DAYS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 8:55 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from MAY 5 19 57 to APR. 11 19 62 that (I) (we) last saw the deceased alive on APR. 9 19 62 and that death occurred 8:55 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
J. E. Bowman | | 22b. DATE SIGNED
APR. 14, 1962 | |
| 22c. PHYSICIAN'S NAME (Type)
J. E. Bowman, M.D. | | 22d. ADDRESS
4021 - 18TH ST., N.E. | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
Burial | | 23b. DATE THEREOF
4/12/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION (City, town, or county) (State)
Colmar Manor Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
F. Gasch's Sons | | 25a. REC'D BY REGISTRAR
DATE APR 16 '62 | |
| ADDRESS
Hyattsville, Maryland | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Hearn | |

1937

CERTIFICATE OF DEATH

1937

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

11. Name of informant: [illegible]
12. Address of informant: [illegible]
13. Signature of informant: [illegible]
14. Date of completion: [illegible]

15. Date of filing: [illegible]
16. Date of death: [illegible]
17. Date of registration: [illegible]
18. Date of completion: [illegible]
19. Date of filing: [illegible]
20. Date of death: [illegible]
21. Date of registration: [illegible]
22. Date of completion: [illegible]
23. Date of filing: [illegible]
24. Date of death: [illegible]
25. Date of registration: [illegible]
26. Date of completion: [illegible]
27. Date of filing: [illegible]
28. Date of death: [illegible]
29. Date of registration: [illegible]
30. Date of completion: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04975
04972

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
3 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | d. STREET ADDRESS
44 Cottage City 3803 37th Ave. | |
| 3. NAME OF DECEASED (Type or print)
First Harry Middle M Last Richardson | | 4. DATE OF DEATH
Month April Day 25 Year 1962 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
18 Dec. 1889 |
| 9. AGE (In years last birthday)
72 yrs. | | IF UNDER 1 YEAR
Months 72 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
City Post Office | |
| 11. BIRTHPLACE (County & State, or foreign country)
Patterson N.J. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Joseph Richardson | | 14. MOTHER'S MAIDEN NAME
Virginia ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
101-1544 | |
| 17. INFORMANT
Mary G. Richardson, wife | | Address above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart disease
(c) Bilat. pulm. congestion
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Apr 22nd , 1962, to Apr 28th , 1962, that (I) (we) last saw the deceased alive on Apr 27th , 1962, and that death occurred at 6:15AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. Till Bergemann | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Till Bergemann | | 22d. ADDRESS
53A Crescent Rose a green belt | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/28/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln | | 23d. LOCATION (City, town or county) (State)
Colmar Manor, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Malley's Funeral Home Inc. | | 25a. REC'D BY REGISTRAR
DATE APR 30 '62 | |
| ADDRESS Mt. Rainier Md. | | 25b. REGISTRAR'S SIGNATURE
Arthur L. House | |

(M)

(1)

Prince Georges

Chowry

8 days

Postage 012

Prince Georges General Hospital

2802 27th Ave.

Harry

Albany

April 18

32

18 Dec. 1889

Miss

Letter

George

City of New York

Richmond

Virginia

Wm. A. Richardson

Richmond, Virginia

Richmond, Virginia

Richmond, Virginia

W. T. T. T. T.

1889/12/18

Richmond, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04976 CERTIFICATE OF DEATH 04973

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY PRINCE GEORGE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE VA b. COUNTY ALEXANDER | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CHEVERLY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ALEXANDER 83x-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
ADSACORDA NURSING HOME | | d. STREET ADDRESS
310 ORVILLE ST | |
| 3. NAME OF DECEASED (Type or print)
First EVA Middle A. Last ROBERTSON | | 4. DATE OF DEATH
Month APRIL Day 14 Year 1962 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept 26, 1878 |
| 9. AGE (In years last birthday)
83 yrs. | | 10. IF UNDER 1 YEAR
Months 10 Days 4 Hours 10 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 11. BIRTHPLACE (County & State, or foreign country)
PRINCE GEORGE'S COUNTY MD | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
GEORGE DENNISON | | 14. MOTHER'S MAIDEN NAME
ALICE SUMMERS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
GLADYS E HOLDEN | | Address 2230 Kearney ST NE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO
(b) Generalized arteriosclerosis
(c) Generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
10 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 5 Jan 1962 to 13 April 1962 that (I) (we) last saw the deceased alive on 13 April 1962 and that death occurred at 7 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
John K. HOLE | | 22b. DATE SIGNED
14 April 1962 | |
| 22c. PHYSICIAN'S NAME (Type)
John K. HOLE | | 22d. ADDRESS
6300 RIVERDALE RD. RIVERDALE MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
4/17/62 | 23c. NAME OF CEMETERY OR CREMATORY
ADDISON CHAMBER CEM | 23d. LOCATION (City, town or county) (State)
SEATonsant PR GEO. CO MD |
| 24. FUNERAL DIRECTOR'S SIGNATURE
W.W. Chambers G | | 25a. REC'D BY REGISTRAR
APR 17 '62 | |
| ADDRESS
517-11 ST SE | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hume | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04977

CERTIFICATE OF DEATH

04974

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN b 40 min
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 30 Cedar Heights
d. STREET ADDRESS 1 6221 Lee Place
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Baby Girl Robinson | | 4. DATE OF DEATH
Month Day Year April 16 19 62 | |
| 5. SEX
Female | 6. COLOR OR RACE
Black | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
16 April 1962 |
| 9. AGE (In years last birthday) yrs. Months Days | | IF UNDER 1 YEAR
Hours Min. 40 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME
Roland F | | 14. MOTHER'S MAIDEN NAME
Mary Helen Jenkins | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. Mother | |
| 17. INFORMANT
Same as above | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Atelectasis
762.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Possible dermoid tumor of neck
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 4/16/1962 to 4/16/62, that (I) (we) last saw the deceased alive on 4/16/62, and that death occurred at 2:50 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Salvatore Battiatto, M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Salvatore Battiatto, M.D. | | 22d. ADDRESS 7389 Reg Rd - Hyattsville | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE THEREOF May 5, 1962 | 23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital Cheverly, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Harry W. Penn, Jr., Administrator | | 25a. REC'D BY REGISTRAR DATE MAY 8 '62 | |
| | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hume | |

VR A15 (4)
15M 7/61

2-046516

M

TOTAL: 100.00%

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FOR STATE
HEALTH DEPT.
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VR A15ME
5M 1/62

04978

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
04975

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Riverdale
c. LENGTH OF STAY IN b
D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Leland Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
68 Berwyn Heights
d. STREET ADDRESS
8914 59th., Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Lucian
First
Rodriguez
Middle
April
Last
25, 1962
4. DATE OF DEATH
Month
Day
Year | | 5. SEX
Male
6. COLOR OR RACE
White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH
Jan 8, 1895
9. AGE (in years last birthday)
67 yrs.
IF UNDER 1 YEAR
Months
Days
IF UNDER 24 HRS.
Hours
Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Printer
10b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't.
11. BIRTHPLACE (State or foreign country)
Porta Rico
12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Unknown Rodriguez
14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes
16. SOCIAL SECURITY NO.
W.W. 1
17. INFORMANT
None
Address
Ludwig George Rodriguez, 8219 16th. Ave., Hyattsville, Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary Occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
(b) Chronic Coronary Vascular disease
(c) General arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
none that I know
INTERVAL BETWEEN ONSET AND DEATH
2 hrs
unknown | |
| 20a. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m.
20b. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.
none
20c. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
none
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none
20e. (City or town)
none
(County)
none
(State)
none | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
DATE SIGNED
4/26/62 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial
22b. DATE THEREOF
5-1-62
22c. NAME OF CEMETERY OR CREMATORY
Arlington National
22d. LOCATION (City, town, or country)
Arlington Virginia | | 23. FUNERAL DIRECTOR
W.W. Chambers Co. Riverdale, Md
24a. REC'D BY REGISTRAR
APR 30 '62
24b. REGISTRAR'S SIGNATURE
Arthur S. Thane | |

Prince George's

Riverdale

D.O.A.

Boynton Heights

Ireland Memorial Hospital

5210 Avenue

Incision

Boatwright

April 27

Male White

Jan 8, 1935

67

Printer

U.S. Gov't

Porto Rico

U.S.A.

Unknown

Unknown

Yes

None

Washington, D.C.
Ludwig George Rodriguez, 6219 16th Ave.

Prof. G. Van Notten, N.D.

4/26/35

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--------------------------------|--|---|--|---|--|---|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY PRINCE GEORGES MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE VIRGINIA b. COUNTY FAIRFAX | | | | | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CAMP SPRINGS | | | | | c. LENGTH OF STAY IN 1b
4 DAYS | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
1800 St Marks Place 83x3 | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
USAF HOSPITAL, ANDREWS AIR FORCE BASE | | | | | d. STREET ADDRESS
FAIRFAX VIRGINIA | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
NORMAN ELLIOTT ROGERS | | | | | 4. DATE OF DEATH
First Middle Last SK
APRIL 20 1962 | | | | | | | | | | | | | | | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
CAU | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JULY 26 1887 | | 9. AGE (In years lost birthday)
74 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SALESMAN | | | | | 10b. KIND OF BUSINESS OR INDUSTRY
HEATING | | | | | 11. BIRTHPLACE (State or foreign country)
AVONDALE, Pa | | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | | | |
| 13. FATHER'S NAME
EBONEZER ROGERS | | | | | 14. MOTHER'S MAIDEN NAME
ELLIOTT | | | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | | | | 16. SOCIAL SECURITY NO.
578072120 | | | | | 17. INFORMANT
(Son) Col Norman Rogers, Jr. Fairfax, Va. | | | | | Address 1800 St Marks Pl | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Collapse
151X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Gastric Carcinoma
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
less than 1 hr | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
N/A | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. Month Day Year
19 | | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 17 April 1962 to 20 April 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 20 April 1962 , and that death occurred at 6:55 PM from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
Stanley R. Payne | | | | | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 20 April 62 | | | | | 22b. DATE SIGNED | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
STANLEY R. PAYNE, LT USN, MC | | | | | | | | | | 22d. ADDRESS
USAF HOSPITAL ANDREWS, ANDREWS AFB, MD. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | | 23b. DATE THEREOF
4/27/62 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
COLUMBIA GARDENS | | | | | 23d. LOCATION (City, town, or county) (State)
ARLINGTON VA. | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
ARLINGTON FUNERAL HOME | | | | | | | | | | ADDRESS
3901 NO FAIRFAX DRIVE ARLINGTON 3/VA | | | | | 25a. REC'D BY REGISTRAR
APR 23 '62 | | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kline | | | | |

04979

04976

CLERK: 1000

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(52)

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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CONFIDENTIAL

1997

1. *Introduction*

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04980 CERTIFICATE OF DEATH 04977

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
e. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 30 Cedar Heights | |
| c. LENGTH OF STAY IN b. 1 day | | d. STREET ADDRESS 915 64th Avenue | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Baby Middle Girl "B" Last Ross | | 4. DATE OF DEATH April 29 1962 | |
| 5. SEX Female | 6. COLOR OR RACE Black | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 28 April 1962 |
| 9. AGE (In years last birthday) 1 yrs. | | IF UNDER 1 YEAR
Months 1 Days 1 | IF UNDER 24 HRS.
Hours 1 Min. 1 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (County & State, or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Edward Ross | | 14. MOTHER'S MAIDEN NAME Wilma Mayo | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. 754-5 | |
| 17. INFORMANT Wilma Mayo | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Congenital Heart Disease
754-5 DUE TO Bilateral Pulmonary Atelectasis
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Prematurity (Twin) B
(b) (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year 19
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/28 1962 to 4/29 1962, that (I) (we) last saw the deceased alive on 4/29 1962, and that death occurred at 7:30 PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Salvatore Battiat | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Salvatore Battiat | | 22d. ADDRESS 7309 Riggs Rd., Hyattsville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF 5/4/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. | | 23d. LOCATION (City, town or county) (State) Cheverly, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator | | 25a. REC'D BY REGISTRAR MAY 8 '62 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

01897

CHARTER OF OATHS

14980

(M)

(C)

(1)

CHARTER OF OATHS

14980

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CHARTER OF OATHS

CERTIFICATE OF DEATH

04981

Item 8 Film G312 5/7/62 jwk

04978

| | | | |
|---|------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY
<i>Prince Georges</i> | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE
<i>MD.-D.C.</i>
b. COUNTY
<i>Prince Georges</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Suitland</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>24 Washington</i> | |
| c. LENGTH OF STAY IN 1b
<i>2 Month</i> | | d. STREET ADDRESS
<i>5303 Valley Rd., S.E.</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Suitland Nursing Home, Inc</i> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<i>Theodosia Roudabush</i> | | 4. DATE OF DEATH
<i>April 26, 19 62</i> | |
| 5. SEX
<i>F</i> | 6. COLOR OR RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>5/4/1896 1894 67</i> |
| 9. AGE (In years last birthday)
<i>67</i> | | 10. IF UNDER 1 YEAR
Months Days | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<i>West Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.G.</i> | |
| 13. FATHER'S NAME
<i>Henry Moore</i> | | 14. MOTHER'S MAIDEN NAME
<i>Curry</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
<i>no</i> | | 16. SOCIAL SECURITY NO.
<i>5303 Valley Rd., S.E.</i> | |
| 17. INFORMANT
<i>Mrs. Eleanor Smith, Washington 27, D.C.</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>
DUE TO (b) <i>Cerebral Arteriosclerosis</i>
DUE TO (c) <i>4 mo.</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <i>19</i> | |
| 20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20e. (City or town) | | 20f. (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>march 1961</i> to <i>April 26, 1962</i> , that (I) (we) last saw the deceased alive on <i>April 25, 1962</i> , and that death occurred at <i>6:25 A.M.</i> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Frank S. Pellegrini</i> M.D. | | 22b. DATE SIGNED
<i>4/26/62</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>Frank S. Pellegrini</i> | | 22d. ADDRESS
<i>3409 Ala Ave SE</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
<i>Burial April 30-62</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>Arlington National</i> | | 23d. LOCATION (City, town or county) (State)
<i>Arlington, Virginia</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Seminions Bros 1661 Good Hope Rd SE</i> | | 25a. REC'D BY REGISTRAR
DATE <i>APR 30 '62</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>William S. Thomas</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04982

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04979

Item 4 Film G312 5/3/62 iwk

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN b | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | |
| Prince George County | | Maryland | | D.C.A. | | Prince George Hospital | |
| 3. NAME OF DECEASED
(Type or print) | | First | | Middle | | Last | |
| Alfred | | Tennyson | | Rowley | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| Male | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Nov. 10, 1911 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Sheet Metal Worker | | Construction | | New York | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Samuel Rowley | | Unknown | | No | | 217-05-4891 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | 19. WAS AUTOPSY PERFORMED? | | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| (Wife) | | Acute Coronary Occlusion | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Natural Causes | |
| Address | | PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) | | INTERVAL BETWEEN ONSET AND DEATH | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: | |
| Same as 2d. | | 4-20-1 | | 4 yrs | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| | | DUE TO | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| | | (b) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DUE TO | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | (c) | | | | DATE SIGNED | |
| | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | Address (Street, city, town, or county) | |
| | | none that I know | | | | April 27, 1962 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or country) (State) | |
| Burial | | 4/30/62 | | Fort Lincoln | | Colmar Manor, Md | |
| 23. FUNERAL DIRECTOR | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | |
| Malley's Funeral Home | | APR 30 '62 | | C. S. Raimier | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

Prince George County

University

D.O.B.

Woodward

Prince George Hospital

3708 Taylor Street

Alfred

Thompson

62

Kate

White

Nov. 10, 1911

Robert Walter Fowler

Donation

New York

U.S.A.

Samuel Fowler

Thompson

(Wife)

No. 11-10-1911 Mrs. Ruth Fowler - - same as 34

(1)

Dr. T. C. ...
...
...

...
...
...

...
...
...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|--|--|--------------------------------------|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Prince Georges
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b 2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Prince Georges
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 4310 Baltimore Ave.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print) Baby Boy Royal | | | 4. DATE OF DEATH April 16 19 62 | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 14 April 1962 | | 9. AGE (In years last birthday) yrs. 2 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Clifford Arden Royal | | | | | 14. MOTHER'S MAIDEN NAME Donetta Rea Wilson | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Clifford Royal Same as #2 Father | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 773.5 DUE TO Prematurity - with Immaturity
(b) Respiratory Distress Synd -
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from April 14, 1962 to April 16, 1962, that (I) (we) last saw the deceased alive on April 16, 1962, and that death occurred on April 16, 1962, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Dr. Salvatore Battiatto M.D. | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED April 17, 1962 | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Salvatore Battiatto | | | | | 22d. ADDRESS 7305 Ruggs Rd Hyattsville | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 4/17/62 | | 23c. NAME OF CEMETERY OR CREMATORY Evergreen | | 23d. LOCATION (City, town or county) (State) Bladensburg Md. | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Alfred S. Burg | | | | | ADDRESS 16 Hyattsville, Md. | | 25a. REC'D BY REGISTRAR APR 19 62 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus |

2-048532

1933

01380

1. Name of person: *John Doe*
 2. Address: *123 Main St, New York, NY*
 3. Date of birth: *Jan 1, 1900*
 4. Sex: *Male*
 5. Race: *White*
 6. Height: *5' 8"*
 7. Weight: *175 lbs*
 8. Eyes: *Blue*
 9. Hair: *Brown*
 10. Occupation: *Teacher*
 11. Education: *High School Graduate*
 12. Marital Status: *Single*
 13. Previous Service: *None*
 14. Other Remarks: *Good character, reliable.*

15. Date of entry: *April 15, 1933*
 16. By whom: *J. A. Smith*
 17. Signature: *[Signature]*
 18. Initials: *[Initials]*
 19. Date of departure: *May 1, 1933*
 20. By whom: *J. A. Smith*
 21. Signature: *[Signature]*
 22. Initials: *[Initials]*

John Doe, 123 Main St, New York, NY
Teacher, High School Graduate
Single, Good character, reliable.

23. Date of departure: *May 1, 1933*
 24. By whom: *J. A. Smith*
 25. Signature: *[Signature]*
 26. Initials: *[Initials]*
 27. Date of entry: *April 15, 1933*
 28. By whom: *J. A. Smith*
 29. Signature: *[Signature]*
 30. Initials: *[Initials]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04984
04981
04981

| | | | |
|--|------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY PRINCE GEORGE MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL
c. LENGTH OF STAY IN 1b adm. 8-13-1960
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) LAUREL SANITARIUM | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE 15542
d. STREET ADDRESS 3909 Woodbine Street
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) JANET S. RUTTER | | 4. DATE OF DEATH
Month 4 Day 24 Year 1962 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-16-1874
9. AGE (In years last birthday) 87
If UNDER 1 YEAR: Months 0 Days 0
If UNDER 24 HRS.: Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME UNKNOWN | | 14. MOTHER'S MAIDEN NAME HENRIETTA BARNES | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NO | |
| 17. INFORMANT Mrs. Charles M. Little, (Daughter) | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE 500X DUE TO Ante mortem (puerulent) 500
(b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2 days
(c) DUE TO | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8-13-1960 to 4-24-1962 that (I) (we) last saw the deceased alive on 4-24-1962 and that death occurred at 5 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Inda P. Kraemer M.D. | | 22b. DATE SIGNED 4-24-62 | |
| 22c. PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER | | 22d. ADDRESS LAUREL SANITARIUM LAUREL Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 4-28-1962 | 23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY | 23d. LOCATION (City, town or county) (State) WASHINGTON, D.C. |
| 24. FUNERAL DIRECTOR'S SIGNATURE Joseph Sewler's Sons, Wash. D.C. | | 25a. REC'D BY REGISTRAR APR 27 '62 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. House | | | |

1880

P-15-1814-2

NOV 1 1880

George B. Burtin, Jr. 1880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

04985

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04982

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY PRINCE GEORGES , MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Andrews AFB | | c. LENGTH OF STAY IN 1b
22 | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Forestville | | d. STREET ADDRESS
3507 79th Avenue | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
USAF Hospital Andrews | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Irene Middle Joy Last Sanger | | 4. DATE OF DEATH
Month April Day 13 Year 1962 | |
| 5. SEX
Female | 6. COLOR OR RACE
Cau. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1 Feb 1962 |
| 9. AGE (In years lost birthday)
2 yrs. | | IF UNDER 1 YEAR
Months 2 Days 12 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Not Applicable | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | |
| 11. BIRTHPLACE (State or foreign country)
U.S. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Benjamin Sanger | | 14. MOTHER'S MAIDEN NAME
Mildred (NMI) Stone | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
Not applicable | |
| 17. INFORMANT
BENJAMIN SANGER | | Address 3507 79TH AVE FORESTVILLE, MD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 754.5 DUE TO Congenital heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Mongolism DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
2 mos
2 mos | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12 April 1962 to 13 April 1962 that (I) (we) last saw the deceased alive on 13 April 1962 and that death occurred at 2208M from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
John A. Moore | | 22b. DATE SIGNED
13 April 1962 | |
| 22c. PHYSICIAN'S NAME (Type)
John A. Moore | | 22d. ADDRESS
5571 Auth Road Camp Springs, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
4/16/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
D. C. LODGE CEM | | 23d. LOCATION (City, town, or county) (State)
WASH., DC | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Robert J. ... | | 25a. REC'D BY REGISTRAR
APR 17 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. ... | | | |

2-009647

1903

CENTRAL OFFICE

1903

| Name | | Address | | Occupation | | Remarks | |
|-------------------|--|------------------|--|------------|--|---------|--|
| John Smith | | 123 Main St | | Teacher | | New | |
| Mary Jones | | 456 Oak St | | Homemaker | | New | |
| Robert Brown | | 789 Elm St | | Farmer | | New | |
| Elizabeth White | | 101 Pine St | | Retailer | | New | |
| James Wilson | | 202 Cedar St | | Mechanic | | New | |
| Sarah Davis | | 303 Birch St | | Homemaker | | New | |
| Thomas Miller | | 404 Spruce St | | Teacher | | New | |
| Anna Moore | | 505 Willow St | | Homemaker | | New | |
| George Taylor | | 606 Ash St | | Farmer | | New | |
| Helen Clark | | 707 Hickory St | | Retailer | | New | |
| William Lewis | | 808 Sycamore St | | Mechanic | | New | |
| Charlotte Hall | | 909 Magnolia St | | Homemaker | | New | |
| Frank Adams | | 1010 Poplar St | | Teacher | | New | |
| Grace Baker | | 1111 Chestnut St | | Homemaker | | New | |
| Charles King | | 1212 Walnut St | | Farmer | | New | |
| Dorothy Green | | 1313 Elm St | | Retailer | | New | |
| Edward Scott | | 1414 Oak St | | Mechanic | | New | |
| Margaret Young | | 1515 Pine St | | Homemaker | | New | |
| Harold Allen | | 1616 Cedar St | | Teacher | | New | |
| Lillian Wright | | 1717 Birch St | | Homemaker | | New | |
| Roy Phillips | | 1818 Spruce St | | Farmer | | New | |
| Beatrice Campbell | | 1919 Willow St | | Retailer | | New | |
| Clarence Parker | | 2020 Ash St | | Mechanic | | New | |
| Evelyn Evans | | 2121 Hickory St | | Homemaker | | New | |
| Walter Reed | | 2222 Sycamore St | | Teacher | | New | |
| Frances Cook | | 2323 Magnolia St | | Homemaker | | New | |
| Albert Hill | | 2424 Poplar St | | Farmer | | New | |
| Bertha Bell | | 2525 Chestnut St | | Retailer | | New | |
| Royce Watson | | 2626 Walnut St | | Mechanic | | New | |
| Mildred Price | | 2727 Elm St | | Homemaker | | New | |
| Gordon Fisher | | 2828 Oak St | | Teacher | | New | |
| Lillian Gray | | 2929 Pine St | | Homemaker | | New | |
| Clarence Hall | | 3030 Cedar St | | Farmer | | New | |
| Evelyn King | | 3131 Birch St | | Retailer | | New | |
| Walter Lee | | 3232 Spruce St | | Mechanic | | New | |
| Beatrice Scott | | 3333 Willow St | | Homemaker | | New | |
| Harold Adams | | 3434 Ash St | | Teacher | | New | |
| Lillian Baker | | 3535 Hickory St | | Homemaker | | New | |
| Clarence Clark | | 3636 Sycamore St | | Farmer | | New | |
| Evelyn Evans | | 3737 Magnolia St | | Retailer | | New | |
| Walter Fisher | | 3838 Poplar St | | Mechanic | | New | |
| Beatrice Gray | | 3939 Chestnut St | | Homemaker | | New | |
| Harold Hall | | 4040 Walnut St | | Teacher | | New | |
| Lillian King | | 4141 Elm St | | Homemaker | | New | |
| Clarence Lee | | 4242 Oak St | | Farmer | | New | |
| Evelyn Scott | | 4343 Pine St | | Retailer | | New | |
| Walter Adams | | 4444 Cedar St | | Mechanic | | New | |
| Beatrice Baker | | 4545 Birch St | | Homemaker | | New | |
| Harold Clark | | 4646 Spruce St | | Teacher | | New | |
| Lillian Evans | | 4747 Willow St | | Homemaker | | New | |
| Clarence Fisher | | 4848 Ash St | | Farmer | | New | |
| Evelyn Gray | | 4949 Magnolia St | | Retailer | | New | |
| Walter Hall | | 5050 Poplar St | | Mechanic | | New | |
| Beatrice King | | 5151 Chestnut St | | Homemaker | | New | |
| Harold Lee | | 5252 Walnut St | | Teacher | | New | |
| Lillian Scott | | 5353 Elm St | | Homemaker | | New | |
| Clarence Adams | | 5454 Oak St | | Farmer | | New | |
| Evelyn Baker | | 5555 Pine St | | Retailer | | New | |
| Walter Clark | | 5656 Cedar St | | Mechanic | | New | |
| Beatrice Evans | | 5757 Birch St | | Homemaker | | New | |
| Harold Fisher | | 5858 Spruce St | | Teacher | | New | |
| Lillian Gray | | 5959 Willow St | | Homemaker | | New | |
| Clarence Hall | | 6060 Ash St | | Farmer | | New | |
| Evelyn King | | 6161 Magnolia St | | Retailer | | New | |
| Walter Lee | | 6262 Poplar St | | Mechanic | | New | |
| Beatrice Scott | | 6363 Chestnut St | | Homemaker | | New | |
| Harold Adams | | 6464 Walnut St | | Teacher | | New | |
| Lillian Baker | | 6565 Elm St | | Homemaker | | New | |
| Clarence Clark | | 6666 Oak St | | Farmer | | New | |
| Evelyn Evans | | 6767 Pine St | | Retailer | | New | |
| Walter Fisher | | 6868 Cedar St | | Mechanic | | New | |
| Beatrice Gray | | 6969 Birch St | | Homemaker | | New | |
| Harold Hall | | 7070 Spruce St | | Teacher | | New | |
| Lillian King | | 7171 Willow St | | Homemaker | | New | |
| Clarence Lee | | 7272 Ash St | | Farmer | | New | |
| Evelyn Scott | | 7373 Magnolia St | | Retailer | | New | |
| Walter Adams | | 7474 Poplar St | | Mechanic | | New | |
| Beatrice Baker | | 7575 Chestnut St | | Homemaker | | New | |
| Harold Clark | | 7676 Walnut St | | Teacher | | New | |
| Lillian Evans | | 7777 Elm St | | Homemaker | | New | |
| Clarence Fisher | | 7878 Oak St | | Farmer | | New | |
| Evelyn Gray | | 7979 Pine St | | Retailer | | New | |
| Walter Hall | | 8080 Cedar St | | Mechanic | | New | |
| Beatrice King | | 8181 Birch St | | Homemaker | | New | |
| Harold Lee | | 8282 Spruce St | | Teacher | | New | |
| Lillian Scott | | 8383 Willow St | | Homemaker | | New | |
| Clarence Adams | | 8484 Ash St | | Farmer | | New | |
| Evelyn Baker | | 8585 Magnolia St | | Retailer | | New | |
| Walter Clark | | 8686 Poplar St | | Mechanic | | New | |
| Beatrice Evans | | 8787 Chestnut St | | Homemaker | | New | |
| Harold Fisher | | 8888 Walnut St | | Teacher | | New | |
| Lillian Gray | | 8989 Elm St | | Homemaker | | New | |
| Clarence Hall | | 9090 Oak St | | Farmer | | New | |
| Evelyn King | | 9191 Pine St | | Retailer | | New | |
| Walter Lee | | 9292 Cedar St | | Mechanic | | New | |
| Beatrice Scott | | 9393 Birch St | | Homemaker | | New | |
| Harold Adams | | 9494 Spruce St | | Teacher | | New | |
| Lillian Baker | | 9595 Willow St | | Homemaker | | New | |
| Clarence Clark | | 9696 Ash St | | Farmer | | New | |
| Evelyn Evans | | 9797 Magnolia St | | Retailer | | New | |
| Walter Fisher | | 9898 Poplar St | | Mechanic | | New | |
| Beatrice Gray | | 9999 Chestnut St | | Homemaker | | New | |

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FOR STATE
HEALTH DEPT.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be noted in the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04983

DEPARTMENT OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04983

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges County MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince Georges | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Suitland | | c. LENGTH OF STAY IN 1b
50 Years | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Suitland | | d. STREET ADDRESS
4604 Davis Avenue | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
4604 Davis Avenue | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
JOHN COLUMBIA SCHLORB | | | | 4. DATE OF DEATH
Month Day Year
April 25, 1962 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug. 26, 1889 | |
| 9. AGE (In years last birthday)
72 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer, (Ret.) | | 11. BIRTHPLACE (State or foreign country)
Cemetery Springville, Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Leonard Schlorb | | | | 14. MOTHER'S MAIDEN NAME
Maryella Donaldson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW I | | | | 16. SOCIAL SECURITY NO.
577-22-9780 | | | |
| 17. INFORMANT
Viola Marie Schlorb | | | | Address
4604 Davis Ave., Suitland, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion
DUE TO (b) Arteriosclerotic Coronary Vascular Disease - General Arteriosclerosis
DUE TO (c) Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None
INTERVAL BETWEEN ONSET AND DEATH
Sudden
Unknown | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.
Natural Causes | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Natural Causes | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
June 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
— | | 20f. (City or town) (County) (State)
— | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Paul C. Van Natta | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
PAUL C. VAN NATTA, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DATE SIGNED
April 25, 1962 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
4-30-62 | | 22c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL | | 22d. LOCATION (City, town, or county) (State)
ARLINGTON, VIRGINIA | |
| 23. FUNERAL DIRECTOR
W. W. CHAMBERS CO., Riverdale, Md. | | | | 24a. REC'D BY REGISTRAR
DATE APR 30 '62 | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Huns | | | |

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
04984

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale | |
| c. LENGTH OF STAY IN 1b DOA | | d. STREET ADDRESS 5301 Quintana St. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Gen. Hospital | | | |
| 3. NAME OF DECEASED (Type or print)
First RAYMOND Middle PHILLIP Last SHACKLEFORD | | | |
| 4. DATE OF DEATH April 13 1962 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH July 5, 1920 |
| 9. AGE (In years last birthday) 41 yrs. | | IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Fireman | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 11. BIRTHPLACE (State or foreign country) Berryville, Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Mervin Howard Shackleford | | 14. MOTHER'S MAIDEN NAME Lula Mae Smallwood | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. W.W. II 229-34-7630 | |
| 17. INFORMANT Christian Scholly | | Address Baltimore, Md. 6006 BlackFires Cir. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
824X
Conditions, if any, which gave rise to immediate cause (b) Drowning
(a), stating the underlying cause last. (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
In an automobile that ran off the bank of the river | | | |
| 20c. TIME OF INJURY Month, Day, Year
4:15 PM 4/13/ 1962 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River | | 20f. (City or town) Queen Ann Bridge P. G. Md (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE James I. Boyd | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) JAMES I. BOYD | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/17/62 | |
| 22c. NAME OF CEMETERY OR CREMATORY Green Hill | | 22d. LOCATION (City, town, or country) Berryville, Va. | |
| 23. FUNERAL DIRECTOR F. Gasch's Sons | | ADDRESS Hyattsville, Md. | |
| 24a. REC'D BY REGISTRAR APR 18 '62 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thoma | |

Printed by the Government Printer, Wellington.

EARLY ISM

Abstract

20 APR 1955

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1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 26

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04988

CERTIFICATE OF DEATH

Reg. Dist. No 04985

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY PRINCE GEORGES MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY PR. GEO. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE | | | | c. LENGTH OF STAY IN 1b 29 YRS | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 62 HYATTSVILLE | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5020-38th AVENUE | | | | d. STREET ADDRESS 5020-38th AVE. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HARRY Middle SIEGEL Last SIEGEL | | | | 4. DATE OF DEATH Month APRIL Day 16 Year 1962 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-20-1884 | |
| 9. AGE (In years last birthday) 77^{1/2} yrs. | | IF UNDER 1 YEAR Months 7 Days 16 Hours 16 Min. 16 | | IF UNDER 24 HRS. Months 7 Days 16 Hours 16 Min. 16 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSICIAN | | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME GETCHELL | | | | 14. MOTHER'S MAIDEN NAME RIVA MARCUS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. 220-32-7335 | | | |
| 17. INFORMANT OSCAR SIEGEL | | | | Address FT. LAUDERDALE, FLA. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) THROMBOSIS, CEREBRAL
DUE TO ARTERIOSCLEROSIS, GENERALIZED
(b) 3 MONTHS
DUE TO 1 WEEK
(c) 3 MONTHS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from JAN 1, 1962 , to APRIL 16, 1962 , that I last saw the deceased alive on APR. 16, 1962 and that death occurred at 1 A. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Samuel J. Sugar M.D. | | | | ADDRESS (Street, city or town, state) 4637 EASTERN AVE DATE SIGNED 4/16/62 | | | |
| PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR | | | | WASHINGTON 18, DC | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 4/17/62 | | 22c. NAME OF CEMETERY OR CREMATORY NAT'L MEM. PARK | | 22d. LOCATION (City, town, or county) (State) FALLS CHURCH VA | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles Kessel Home ADDRESS 4217-9th NW | | | | 24a. REC'D BY REGISTRAR DATE APR 17 '62 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 04989 | | | | | | 04986 | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>
c. LENGTH OF STAY IN 1b <u>1 yr., 5 mos. & 27 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Glenn Dale Hospital</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>D. C.</u> b. COUNTY <u>-</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>
d. STREET ADDRESS <u>222 F. St., N.E.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Luther</u> <u>Simms</u> | | | | | | 4. DATE OF DEATH
Month <u>4</u> Day <u>22</u> Year <u>19 62</u> | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>Negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>2/28/01</u> | | 9. AGE (In years last birthday) <u>61</u> yrs. | | IF UNDER 1 YEAR
Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Unemployed (unknown)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>S.C.</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 13. FATHER'S NAME
<u>Unknown</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>-</u> | | 17. INFORMANT
<u>Decedent</u> | | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u>
<u>592X</u> DUE TO <u>Chronic glomerulonephritis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>-</u> (c) <u>-</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 weeks</u>
<u>?</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Generalized arteriosclerosis; pulmonary abscess, right upper lobe; cerebro-vascular accidents, bilateral</u> | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u>-</u> e.m. <u>19</u> p.m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/26/1960</u> <u>7:15</u> to <u>11/22/1962</u> , that (I) (we) last saw the deceased alive on <u>11/22/1962</u> , and that death occurred at <u>p.m.</u> from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Moe Weiss</u> | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>4/22/62</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Moe Weiss, M.D.</u> | | | | | | 22d. ADDRESS
<u>Glenn Dale Hospital</u>
<u>Glenn Dale, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>4-27-62</u> | | 23b. DATE THEREOF
<u>4-27-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Lincoln Mem</u> | | 23d. LOCATION (City, town or county) (State)
<u>Suitland Rd</u> <u>MD</u> | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>H.S. Washington & Son</u> | | | | | | ADDRESS
<u>4925 Plane Ave</u> | | 25a. REC'D BY REGISTRAR
<u>APR 27 '62</u> | | 25b. REGISTRAR'S SIGNATURE
<u>William S. Thorne</u> | |

04930

03910

①

Handwritten signature or initials.

Handwritten text at the bottom of the page, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04990 CERTIFICATE OF DEATH 04987

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE D.C. b. COUNTY | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Glenn Dale (RURAL) | | c. LENGTH OF STAY IN 1b
1 yr. 9 mo. | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Washington 47X-3 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Glenn Dale Hospital | | | | d. STREET ADDRESS
701 - E. Capitol | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Myrtle B. Slagle | | | | 4. DATE OF DEATH
Month Day Year
April 19 19 62 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
June 3, 1896 | |
| 9. AGE (In years last birthday)
65 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Carolina, Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
George O. Loving | | | | 14. MOTHER'S MAIDEN NAME
Sarah Dishman | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO.
Decedent | | | |
| 17. INFORMANT
Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease with decompensation
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (b) DUE TO
(a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Chronic pyelonephritis; Generalized arteriosclerosis with chronic brain syndrome. | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
3 months | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 19, 1960, to April 19, 1962, that (I) XXXX last saw the deceased alive on April 19, 1962, and that death occurred at 7:05 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Moe Weiss | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
4/19/62 | |
| 22c. PHYSICIAN'S NAME (Type)
Moe Weiss | | | | 22d. ADDRESS
Glenn Dale Hospital, Glenn Dale, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
April 27-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Loving Family Cem. | | 23d. LOCATION (City, town or county) (State)
Hawertons Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Moe Weiss | | | | ADDRESS
Moe Weiss - Sappokanyok Va. | | 25a. REC'D BY REGISTRAR
DATE APR 30 '62 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

02890

CERTIFICATE OF DEATH

1987

Full name of deceased

John Doe (1915)

1 yr. 9 mos.

John Doe Hospital

1915 - 1916

Female

John A. Doe

1915

1915

1915

1915

1915

1915

1915

1915

1915

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1915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04991

04988

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
PRINCE GEORGES
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN 1b
2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
US AIR FORCE HOSPITAL ANDREWS | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
UPPER MARLBORO
d. STREET ADDRESS
ROUTE #4, BOX 1094
e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
BRIAN
First
THORNTON
Middle
SMITH
Last | | 4. DATE OF DEATH
APRIL
Month
2
Day
19
Year
62 | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
CAUCASIAN | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH
31 MARCH 1962 | | 9. AGE (In years last birthday)
2
yrs. | | IF UNDER 1 YEAR
Months
2
Days
2
Hours
2
Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 10b. KIND OF BUSINESS OR INDUSTRY
NONE | | 11. BIRTHPLACE (County & State, or foreign country)
PRINCE GEORGES, MARYLAND | | | |
| 12. CITIZEN OF WHAT COUNTRY
UNITED STATES | | 13. FATHER'S NAME
DELBERT THORNTON SMITH | | 14. MOTHER'S MAIDEN NAME
CAROLYN ANN CRAIG | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
DELBERT T SMITH (FATHER)
Address
SAME AS ITEM #2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL EDEMA
DUE TO
Conditions, if any, which gave rise to immediate cause (b) BRAIN DAMAGE
(a), stating the underlying cause last. (c) FRACTURED SKULL | | | | INTERVAL BETWEEN ONSET AND DEATH
48 HOURS
48 HOURS
48 HOURS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
CRANIOTABES | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
SKULL FRACTURE INCURRED DURING SPONTANEOUS DELIVERY | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
9:59
p.m.
MARCH 31, 1962 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
USAF HOSPITAL | | | |
| 20f. (City or town)
ANDREWS AFB, PRINCE GEORGES, MD | | 20g. (County)
PRINCE GEORGES | | | | | |
| 20h. (State)
MD | | | | | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 31 MARCH , 19 62 , to 2 APRIL , 19 62 , that (I) XXX last saw the deceased alive on 2 APRIL , 19 62 , and that death occurred at 1030P , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
John A Moore
M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
2 APRIL 1962 | | | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN A MOORE, Major USAF MC | | 22d. ADDRESS
USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
3/6-1962 | | 23c. NAME OF CEMETERY OR CREMATORY
ARL NAT CEMETERY ARLINGTON VA | | | |
| 23d. LOCATION (City, town or county)
WASH | | 23e. REC'D BY REGISTRAR
DATE APR 6 '62 | | | | | |
| 23f. REGISTRAR'S SIGNATURE
Will Chambers Co 517-11-4 ASE (3) DC | | 23g. REGISTRAR'S SIGNATURE
Arthur S. Fiance | | | | | |

2-068362

14

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12
FOR STATE
HEALTH DEPT.

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VR A15ME
SM 1/62

04992 STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
04991

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE District of Columbia b. COUNTY Washington | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 47X-3 | | | |
| c. LENGTH OF STAY IN ID DOA | | | | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital 1417 Holbrook Street N.E. | | | |
| 3. NAME OF DECEASED (Type or print) Clarence William Southard | | | | 4. DATE OF DEATH April 16 19 62 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 5, 1899 62 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY Oil Burner | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Columbus Benjamin Southard | | | | 14. MOTHER'S MAIDEN NAME Laura Virginia Wheakley | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 578-07-7563 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4-20-1 Acute congestive heart failure
Conditions, if any, which gave rise to immediate cause (b) Coronary artery disease- severe
(a), stating the underlying cause last. (c) Cardiovascular renal disease | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE James I. Boyd | | CHIEF MEDICAL EXAMINER | | ASSISTANT MEDICAL EXAMINER | | DATE SIGNED April 17, 1962 | |
| EXAMINER'S NAME (Type) James I. Boyd | | DEPUTY MEDICAL EXAMINER | | Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-20-62 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Washington, D.C. | |
| 23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md. | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | DATE APR 19 '62 | |

04281

Director of Colonies

James George

Washington

DOE

Shaw

James George's General Hospital

General Hospital

April 19

James G. Doe

James G. Doe

James G. Doe

James G. Doe

James G. Doe

James G. Doe

James G. Doe

James G. Doe

James G. Doe

James G. Doe

James G. Doe

James G. Doe

James G. Doe

April 19

James G. Doe

1
FOR STATE
HEALTH DEPT.

04993

MARYLAND STATE DEPARTMENT OF HEALTH
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04989

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY IN 1b
77
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Laurel
d. STREET ADDRESS
606 Main Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Steven Richard Sproles | | 4. DATE OF DEATH
April 24, 1962 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 10, 1957 |
| 9. AGE (In years last birthday)
5 | | 10. IF UNDER 1 YEAR
Months 5 Days 24 Hours 19 Min. 62 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Child | | 10b. KIND OF BUSINESS OR INDUSTRY
Child | |
| 11. BIRTHPLACE (State or foreign country)
Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Lewis Paul Sproles | | 14. MOTHER'S MAIDEN NAME
Thelma M. Dunsmore | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mr. Lewis P. Sproles, Laurel, Md. | | Address 606 Main St., | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 812X INTRACRANIAL INJURY and FRACTURE PELVIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
Struck by truck in street | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
2:00 p.m. April 24, 62 | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
500 Blk. Main St. Laurel, Maryland. | |
| 20f. (City or town)
Laurel | | 20g. (County)
Howard Co., Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Paul C. Van Natta | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
PAUL C. VAN NATTA, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
4/25/62 | |
| Address (Street, city, town, or county)
550 WASH. BLVD., LAUREL, MD. | | 22d. LOCATION (City, town, or country)
Howard Co., Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
4/28/62 | |
| 22c. NAME OF CEMETERY, OR CREMATORY
Baptist Church Cemetery | | 22d. LOCATION (City, town, or country)
Howard Co., Md. | |
| 23. FUNERAL DIRECTOR
Arthur S. K... | | 24a. REC'D BY REGISTRAR
APR 30 '62 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. K... | | 24c. REGISTRAR'S SIGNATURE
Arthur S. K... | |

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

Prince George's

Marshall

Prince George's

Overly

Levy

Prince George's General Hospital

606 Main Street

X

Steven

Richard

Stephen

April

62

White

Jan. 10, 1957

5

Child

Washington, D. C.

U.S.A.

Levin Paul Boyles

Thelma M. Boyles

606 Main St.

None

Mr. Levin P. Boyles

Levin, Pa.

International League of Women's Clubs

Struck by truck in street

2:00 April 24, 62 X 500 E. Main St. Laurel, Maryland.

X

W. C. Van Meter, M.D.

W. C. Van Meter, M.D.

4/25/62

W. C. Van Meter, M.D.

W. C. Van Meter, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

049934
04990

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges County
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY IN 1b
18 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince Georges General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince Georges County
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Beltsville
d. STREET ADDRESS
Maryland Ave.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Thelma M. Sydnor | | 4. DATE OF DEATH
Month April Day 24 Year 19 62 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-11-22 |
| 9. AGE (In years last birthday)
39 yrs. | | IF UNDER 1 YEAR
Months 3 Days 9 | IF UNDER 24 HRS.
Hours 3 Min. 9 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | 11. BIRTHPLACE (County & State, or foreign country)
Richmond Cty., Va. |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Thomas Luther Moss | |
| 14. MOTHER'S MAIDEN NAME
Nola L. Sanders | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
no | |
| 16. SOCIAL SECURITY NO.
no | | 17. INFORMANT
Address Maryland Ave., Beltsville, Md.
Melvin Sydnor, Sr. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) MASSIVE INTERNAL HEMORRHAGE
191-9
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
DUE TO (b) DIFUSE CARCINOMATOSIS
DUE TO (c) SQUAMOUS CELL CARCINOMA | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from April 6, 1962 , to April 24, 1962 that (I) (we) last saw the deceased alive on April 24, 1962 , and that death occurred at 8:00 P.M. the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Peter Duus
M.D. | | 22b. DATE SIGNED
4-25-62 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Peter Duus | | 22d. ADDRESS
6124 Central Ave., Capitol Hgts., Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
4-27-62 | 23c. NAME OF CEMETERY OR CREMATORY
Rappahannock Baptist | 23d. LOCATION (City, town or county) (State)
Newland, Virginia |
| 24. FUNERAL DIRECTOR'S SIGNATURE
H. R. Sanford, Montross, Va. | | 25a. REC'D BY REGISTRAR
DATE APR 30 '62 | |
| | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Haines | |

04330

REVENUE OF DEATH

04330

14

THE DEATH OF A PERSON WHOSE NAME IS NOT KNOWN TO THE DEPARTMENT OF HEALTH

IN THE CITY OF NEW YORK

IN THE YEAR 1911

IN THE MONTH OF JANUARY

IN THE DAY OF THE 11TH

IN THE YEAR 1911

IN THE CITY OF NEW YORK

IN THE MONTH OF JANUARY

IN THE DAY OF THE 11TH

IN THE YEAR 1911

IN THE CITY OF NEW YORK

IN THE MONTH OF JANUARY

IN THE DAY OF THE 11TH

IN THE YEAR 1911

IN THE CITY OF NEW YORK

IN THE MONTH OF JANUARY

IN THE DAY OF THE 11TH

IN THE YEAR 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04932

| | | | |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges Co</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Myattville</u>
c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Myattville, Md.</u>
d. STREET ADDRESS <u>625 Sheridan St.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Fern</u> First <u>Edith</u> Middle <u>Jacobs</u> Last | | 4. DATE OF DEATH <u>April</u> Month <u>22</u> Day <u>1962</u> Year | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 20 - 1990</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Albert Carow</u> | | 14. MOTHER'S MAIDEN NAME <u>Johanna Kilbuck</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Marion T. Patrick</u> Address <u>1422 Quaker St. Fort Myattville, Md.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatous</u>
DUE TO <u>Carcinoma left breast</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/2</u> , 19 <u>55</u> , to <u>4/22</u> , 19 <u>62</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>4/21</u> , 19 <u>62</u> , and that death occurred at <u>2:30</u> P.M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>M. F. Ottman</u> M.D. | | 22b. DATE SIGNED <u>4/22/62</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>M. F. OTTMAN</u> | | 22d. ADDRESS <u>401 Kennedy St. NW DC</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE HEREOF <u>April 25 - 1962</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St. SE</u> | | 25a. REC'D BY REGISTRAR <u>APR 24 '62</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04936 CERTIFICATE OF DEATH 04933

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY in 1b 46 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 Mt Rainier
d. STREET ADDRESS 1 4526 32nd S t.,
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Guiseppe Vincelli | | 4. DATE OF DEATH Apr. 22 1962 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 18, 1930 |
| 9. AGE (In years last birthday) 32 yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick layer for Wheaton Co. | | 10b. KIND OF BUSINESS OR INDUSTRY Brick layer for Wheaton Co. | |
| 11. BIRTHPLACE (County & State, or foreign country) Campobasso, Italy | | 12. CITIZEN OF WHAT COUNTRY? Italy | |
| 13. FATHER'S NAME Michele Vincelli | | 14. MOTHER'S MAIDEN NAME Mariantonia Pietrantonio | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 577X | | 16. SOCIAL SECURITY NO. 578-50-1463 | |
| 17. INFORMANT Aldina Vincelli | | Address above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Peritonitis
DUE TO Multiple perforations and fistulae of large and small intestine
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Adhesions, multiple, post-surgical
DUE TO Adhesions, multiple, post-surgical | | INTERVAL BETWEEN ONSET AND DEATH 1 WEEK

Weeks
Months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Mar. 7 , 1962, to Apr. 22 , 1962, that (I) (we) last saw the deceased alive on Apr. 21 , 1962, and that death occurred at 12:35 A.M. the causes and on the date stated above. | | | |
| 22a. SIGNATURE John H. Bayly | | 22b. DATE SIGNED APR 26 '62 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN H. BAYLY | | 22d. ADDRESS 1835 Eye N.W., WASH D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 4/25/62 | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | 23d. LOCATION (City, town or county) (State) Colmar Manor, Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE Kalley's Funeral Home | | 25a. REC'D BY REGISTRAR Manuel
DATE APR 26 '62 | |
| ADDRESS 3200 Rd. and | | 25b. REGISTRAR'S SIGNATURE William S. Kneiss | |

I have a copy of the book, and it is a very good one.

12. 7. 61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04997
04994
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|--|--|--------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George
MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince George | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write nearest town)
Chesley | | c. LENGTH OF STAY in 1b
7 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Seat Pleasant | | d. STREET ADDRESS
510 68th Ave | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George General Hospital | | | | d. STREET ADDRESS
510 68th Ave | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print) Harold First E Middle Walker Last | | | | 4. DATE OF DEATH
Apr. Month 10 Day 19 Year 62 | | | | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 7, 1900 | | 9. AGE (In years last birthday)
61 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Woodworking | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country)
Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Charles Edward Walker | | | | | | 14. MOTHER'S MAIDEN NAME
Mary Frances Reed | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs Pauline Walker-wife 510-68th ave Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
490X IMMEDIATE CAUSE (a) Pneumonia left upper lobe
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. (c) 490X
DUE TO
DUE TO
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Bronchogenic Carcinoma
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/3/62 , 19 Apr. 10 , to 1962 , that (I) (we) last saw the deceased alive on 1962 , and that death occurred at 5:35 PM from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
George William Ware M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. George William Ware | | | | | | 22d. ADDRESS
1835 Eye St NW, Washington, D.C. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-13-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | | | 23d. LOCATION (City, town or county) (State)
Suitland, Md. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Lee Funeral Home | | | | | | ADDRESS
Washington DC | | 25a. REC'D BY REGISTRAR
Apr 13 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Kline | | | |

1934

1934

OFFICE OF THE

REPORT OF THE

COMMISSIONER OF

THE

STATE OF

NEW YORK

FOR THE YEAR

ENDING

APRIL 30, 1934

BY

THE

COMMISSIONER

OF

THE

STATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04998

04995

| | | | |
|---|------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cottage City, Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>44 Cottage City</u> | |
| c. LENGTH OF STAY IN 1b
<u>6 years</u> | | d. STREET ADDRESS
<u>3708 38th Ave.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>3708 38th Avenue</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Sue</u> Middle <u>Wallin</u> Last <u>Wallin</u> | | 4. DATE OF DEATH
Month <u>April</u> Day <u>30</u> Year <u>1962</u> | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 1880</u> |
| 9. AGE (In years last birthday)
<u>81</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housekeeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Chicago, Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>United States</u> | |
| 13. FATHER'S NAME
<u>L. P. A. Wallin</u> | | 14. MOTHER'S MAIDEN NAME
<u>Louisa M. Frickson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u> </u> | |
| 17. INFORMANT
<u>Elvira W. Greenwood same as #2</u> | | Address
<u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>chronic congestive failure</u>
DUE TO <u>410X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.
(b) <u>aortic & mitral valve disease</u>
DUE TO
(c) <u>hypertensive cardio-vascular disease</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u> </u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | |
| 20c. TIME OF INJURY
Month <u> </u> Day <u> </u> Year <u>19</u>
Hour <u> </u> a. m. <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u> </u> 19 <u> </u> , to <u> </u> 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>George J. Hageage</u>
M.D. | | 22b. DATE
<u>5/2/62</u>
SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. George J. Hageage</u> | | 22d. ADDRESS
<u>3717 38th Ave., Cottage City, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>5/3/62</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill</u> | 23d. LOCATION (City, town, or county) (State)
<u>Suitland, Md.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Francis Gasch's Sons</u> | | 24. ADDRESS
<u>Hyattsville, Md.</u> | |
| 25a. REC'D BY REGISTRAR
DATE <u>MAY 4 '62</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Thomas</u> | |

00130

STATEMENT OF DEATH

00930

(M)

(1)

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FEDERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04999

04996

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkland
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 35--Maryland Ave. S. E. | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkland
d. STREET ADDRESS 35--Maryland Ave., S.E.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) REV. ROBERT L. WHITTENBURG
First Middle Last
4. DATE OF DEATH April 17th 1962
Month Day Year | | | | 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Apr. 21, 1882
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister 10b. KIND OF BUSINESS OR INDUSTRY Retired 11. BIRTHPLACE (County & State, or foreign country) Missouri 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Thomas A. Whittenburg 14. MOTHER'S MAIDEN NAME Mary E. Whitehurst | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Sarah M. Whittenburg -35 Maryland Ave Md.
Address | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
DUE TO Coronary atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis
DUE TO General Arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none of note 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) natural Causes | | | | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from March 1, 1962 to April 17, 1962 that (I) (we) last saw the deceased alive on Apr. 16, 1962 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Dr. Paul C. Van Natta M.D. 22b. DATE SIGNED April 17th 1962 | | | | 22c. PHYSICIAN'S NAME (Type) Dr. Paul C. Van Natta 22d. ADDRESS 5440--Silver Hill Rd., Suitland Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Apr. 20, 1962 | | 23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery | | 23d. LOCATION (City, town or county) Forestville, Maryland (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE 1661--Good Hope Rd., SE Washington 20 DC | | | | 25a. REC'D BY REGISTRAR APR 19 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Brown | | | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, the Deputy Medical Examiner should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05000

04937

| | | | | |
|--|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Prince George County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland b. COUNTY
Prince George | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
D.O.A. | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince George Hospital | | e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
17 Forestville | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Ralph Allen Williams | | d. STREET ADDRESS
5419 Pine Street | | |
| 5. SEX
Male | | 4. DATE OF DEATH
Month Day Year
April 27, 1962 | | |
| 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 8. DATE OF BIRTH
March 27, 1912 | | 9. AGE (In years last birthday) yrs. Months Days
50 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bus Operator | | 10b. KIND OF BUSINESS OR INDUSTRY
D.C. Transit | | |
| 11. BIRTHPLACE (State or foreign country)
Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
George A. Williams | | 14. MOTHER'S MAIDEN NAME
Mary Alice Spell | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | 16. SOCIAL SECURITY NO.
578-10-7358 | | |
| 17. INFORMANT (Wife)
Mrs. Doris Williams - Same as 2d | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Coronary Artery Disease
(a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
— | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
Unknown |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
natural causes | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m.
— 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
— | | 20f. (City or town) (County) (State)
— | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE
Paul C. VanNatta | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type)
Dr. Paul C. VanNatta | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
4-30-1962 | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln | | 22d. LOCATION (City, town, or country) (State)
Prince George County Md | | |
| 23. FUNERAL DIRECTOR
Robert A Mattingly | | 24. REC'D BY REGISTRAR
APR 30 '62 | | |
| ADDRESS
Wash DC | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Huns | | |

(M)

(1)

George A. Williams
E.C. Transit Washington, D.C.
March 27, 1912
Male
Race
Allen
Williams
April 27, 1912
Prince George Hospital
519 Pine Street
Chesley
D.C.
Harrisburg
Prince George County
Maryland
41937

No. 518-10-1556 Mrs. Doris Williams - Base as 25
George A. Williams
E.C. Transit Washington, D.C.
March 27, 1912
Male
Race
Allen
Williams
April 27, 1912
Prince George Hospital
519 Pine Street
Chesley
D.C.
Harrisburg
Prince George County
Maryland
41937

Dr. Paul C. Vannoy
April 27, 1912
518-10-1556 - J. Williams
41937

1
FOR STATE
HEALTH DEPT.

05001

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04938

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY in 1b
36 Lanham | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | d. STREET ADDRESS
9120 Fowler Lane | |
| 3. NAME OF DECEASED
(Type or print)
Walter Lanier Wilson Jr | | 4. DATE OF DEATH
Month April Day 3 Year 19 62 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 11, 1942 |
| 9. AGE (In years last birthday)
20 yrs. | | IF UNDER 1 YEAR
Months 20 Days 20 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Barber | | 10b. KIND OF BUSINESS OR INDUSTRY
Barber | |
| 11. BIRTHPLACE (State or foreign country)
District of Columbia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Walter Lanier Wilson Sr. | | 14. MOTHER'S MAIDEN NAME
Helen Margaret Curtin | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
216-40-9534 | |
| 17. INFORMANT
Walter Lanier Wilson Sr., same as # 2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage and shock
DUE TO (b) Crushed skull
DUE TO (c) Crushed skull
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Passenger in an automobile that overturned | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Passenger in an automobile that overturned | |
| 20c. TIME OF INJURY
Month, Day, Year 12:30 xx 4/3/62 | | 20d. INJURY OCCURRED <input checked="" type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> Road | |
| 20e. PLACE OF INJURY (factory, street, office bldg., etc.)
Lanham P. G. Md | | 20f. CITY OR TOWN (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
James I. Boyd | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
James I. Boyd | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
4/3/62 | |
| Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
4-6-1962 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Mt Olivet Cemetery | | 22d. LOCATION (City, town, or country) (State)
Washington, D.C | |
| 23. FUNERAL DIRECTOR
W. W. Chambers 80 Riverdale, Md | | 24a. REC'D BY REGISTRAR
APR 6 '62 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Hines | | | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05002

04939

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY in 1b 5 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)
e. STATE Maryland b. COUNTY Prince Georges County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro
d. STREET ADDRESS R.F.D. Box 3703
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
Harrison Wade Windsor | | 4. DATE OF DEATH
Month April Day 8 Year 1962 | | 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 3-2-99
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY FARMING | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JOHN WINDSOR 14. MOTHER'S MAIDEN NAME AGNES WINDSOR | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)
16. SOCIAL SECURITY NO. 215-14-7127 17. INFORMANT Wilson Windsor, Upper Marlboro, Md. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1. Pulmonary Edema
(b) 2. Congestive Heart Failure
(c) 3. Left Coronary Thrombosis (fresh)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 4-3-1962 , to 4-8-1962 that (I) (we) last saw the deceased alive on 4-8-1962 , and that death occurred at 5:50 P.M. , the causes and on the date stated above.
22a. SIGNATURE Clark Holmes 22b. DATE SIGNED 4/9/62
22c. PHYSICIAN'S NAME (Type) Upper Marlboro Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 4-11-62 23c. NAME OF CEMETERY OR CREMATORY MC CARMEL 23d. LOCATION (City, town or county) Upper MARIBORO, MD. | | 24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Frank 25a. REC'D BY REGISTRAR APR 12 '62 25b. REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO JURY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05003 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05000

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|---|--------------------------------|---|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland b. COUNTY
Pr. Georges' | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington 27, D.C. | | | |
| c. LENGTH OF STAY IN 1b
77 | | | | d. STREET ADDRESS
7800 Largo Road | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
Nellie | | First
M.aria | | Middle
Windsor | | Last | |
| 4. DATE OF DEATH
April 10 1962 | | Month
April | | Day
10 | | Year
1962 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/28/87 | 9. AGE (In years last birthday)
74 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Tenant Own Home | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Thomas Henry Roberson | | | | 14. MOTHER'S MAIDEN NAME
(nee Tucker) Georgeiana (Last Name Unknown) Route # 3 Box 604E | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Clarence Windsor Edgewater, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular accident
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease
(c) Cardiovascular renal disease
DUE TO
cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Fracture of the right hip | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell on the bed room floor | | | | | |
| 20c. TIME OF INJURY
Month Day Year
3/23 4/24/62
Hour a.m.
1:00pm | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Largo P. G. Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
James L. Boyd | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
JAMES L. BOYD, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DATE SIGNED
4/10/62 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
4/13/62 | | 22c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 22d. LOCATION (City, town, or country) (State)
Bladensburg Maryland | |
| 23. FUNERAL DIRECTOR
Ritchie Bros. Fun'l Home-Upper Marlbor | | | | 24a. REC'D BY REGISTRAR
APR 23 '62 | | 24b. REGISTRAR'S SIGNATURE
Charles S. Thomas | |

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(no other)

(no other)

(no other)

(no other)

(no other)

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(no other)

(no other)

(no other)

(no other)

(no other)

(no other)

(no other)

(no other)

(no other)

(no other)

(no other)

JAMES I. BOYD, M.D.

1/13/62

1/13/62

1/13/62

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05004

Item 2 File G213 5/21/62 iwk

CERTIFICATE OF DEATH

05001

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>D. C.</u> b. COUNTY <u>✓</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland, Md. Wash. 23, D.C. P</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | |
| c. LENGTH OF STAY IN <u>4-24-62 - 4-25-62</u> | | d. STREET ADDRESS <u>3109 Nichols Ave. S.E.</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suitland Nursing Home</u> | | 4. DATE OF DEATH <u>4</u> <u>25</u> <u>1962</u> | |
| 3. NAME OF DECEASED (Type or print) <u>John C. Witt</u> | 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH <u>7-26-81</u> | 9. AGE (In years last birthday) <u>80</u> yrs. | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | 11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroader</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John Witt</u> | | 14. MOTHER'S M maiden NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>705-09-4266</u> | |
| 17. INFORMANT <u>HOSPITAL RECORDS</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARCINOMA, colon & generalized metastasis</u>
153.8 DUE TO (b) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u>
Hour a.m. <u> </u> p.m. <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4/11</u> , 19 <u>62</u> to <u>4/25</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> , 19 <u>62</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Leo H. Muggmon</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) <u>LEO H. MUGGMON M.D.</u> | | 22b. DATE SIGNED <u>3109 NICHOLS AVE SE</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>4-29-62</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Hill GROVE CEMETERY</u> | | 23d. LOCATION (City, town or county) (State) <u>CONNELLSVILLE, PENNA.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home Wash. D.C.</u> | | 25a. REC'D BY REGISTRAR <u>APR 27 '62</u> DATE | |
| ADDRESS <u> </u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

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05005

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05002

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. Geo</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CAMP SPRINGS</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>19 CAMP SPRINGS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>5564-Branch Ave SE</u> | | | | d. STREET ADDRESS
<u>5564-Branch Ave SE</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Romey FRANKLIN Wood</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>April 3 1962</u> | | | |
| 5. SEX
<u>MALE</u> | | 6. COLOR OR RACE
<u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>6-JAN. 1882</u> | |
| 9. AGE (In years lost birthday)
<u>80</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>FARMER</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Thomas F. Wood</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MIRIAM E. BURGESS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
<u>FRANCES E. Wood - SAMEAS-2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thrombosis</u>
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>General Arteriosclerosis</u>
DUE TO
(c) <u>—</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Diabetes mellitus</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Natural causes</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. — 19
p. m. — | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>—</u> | |
| 20f. (City or town)
<u>—</u> | | | | 20g. (County)
<u>—</u> | | 20h. (State)
<u>—</u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 8</u> 1962, to <u>Apr 3</u> 1962 that (I) (we) last saw the deceased alive on <u>Apr 3</u> 1962, and that death occurred at <u>10 PM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Paul C Van Natta</u> | | | | 22b. DATE SIGNED
<u>APR 6 '62</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>PAUL C VAN NATTA</u> | | | | 22d. ADDRESS
<u>5440 Silver Hill Rd Washington 28 DC</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>April 6-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Barnabas Cemetery</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Oxon Hill MD</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Simmons Bros</u> | | | | 25a. REC'D BY REGISTRAR
<u>1661- Good Hope Rd SE Wash. 20 DC</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

05006

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G311 4/26/62 mh

CERTIFICATE OF DEATH

Reg. Dist. No. 05003

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY
PRINCE GEORGE COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville
c. LENGTH OF STAY IN 1b
5 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
CARROLL MANOR (4922 LaSalle Rd) | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
D.C.
b. COUNTY
WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LOCKVILLE, WASHINGTON
d. STREET ADDRESS
2002 P St. N.W.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
ELIZA P. WORTHINGTON | | 4. DATE OF DEATH
Month Day Year
APRIL 20 19 62 | |
| 5. SEX
F. | 6. COLOR OR RACE
W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
APRIL 26, 1865 |
| 9. AGE (In years last birthday)
96 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min.
11 26 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 10b. KIND OF BUSINESS OR INDUSTRY
GEORGETOWN | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CHARLES WORTHINGTON | | 14. MOTHER'S MAIDEN NAME
REBECCA BRITTON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
INFORMANT | |
| 17. ADDRESS
SISTER AGNES PATRICIA (CARROLLMANOR) | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE WITH CON-
gestive Heart Failure
DUE TO (b) GENERALIZED ARTERIOSCLEROSIS
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. | |
| 19. INTERVAL BETWEEN ONSET AND DEATH
10 days | | 20. 4 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 15, 1958 , to April 20, 1962 , that I last saw the deceased alive on April 20, 1962 , and that death occurred at 9 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Thomas F. Collins M.D. 322 H. St. N.E. April 20, 1962 | | | |
| 22a. BURIAL, CREMATION, or other disposition (Specify) | | 22b. DATE THEREOF
4/23/62 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rock Creek | | 22d. LOCATION (City, town, or county) (State)
Washington D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John G. ... | | 24a. REC'D BY REGISTRAR
DATE APR 23 '62 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. ... | | | |

03003

CHINA (1949-1950)

03003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05007 CERTIFICATE OF DEATH 05004

| | | | | | | |
|---|-----------------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY PRINCE GEORGES
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) US AIR FORCE HOSPITAL | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND
b. COUNTY PRINCE GEORGES
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE
d. STREET ADDRESS CONCORD AVENUE
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) ADOLPH | | | 4. DATE OF DEATH APRIL 29 19 62 | | | |
| 5. SEX MALE | 6. COLOR OR RACE CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2 AUGUST 1923 | 9. AGE (In years last birthday) 38 yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIRMAN | | 10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE | | 11. BIRTHPLACE (County & State, or foreign country) unknown | | |
| 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 13. FATHER'S NAME unknown | | | | |
| 14. MOTHER'S MAIDEN NAME unknown | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES
16. SOCIAL SECURITY NO. 017-18-5555 | | | | |
| 17. INFORMANT Records Andrews A. F. Base | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: FRACTURED SKULL AND INTRACRANIAL HEMORRHAGE
IMMEDIATE CAUSE (a) 936.6 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) ALLEGEDLY INVOLVED IN ALTERCATION | | | | |
| 20c. TIME OF INJURY 6:30 p.m. Month, Day, Year APR 29 19 62 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) TAVERN | | |
| 20f. (City or town) BALTIMORE | | 20g. (County) BALTIMORE | | 20h. (State) MD | | |
| 21. I certify that (I) XXXXXX attended the deceased from 29 APRIL 19 62 to 29 APRIL 19 62 , that (I) XXX last saw the deceased alive on DOA 19 62 , and that death occurred at 845P , from the causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE Kenneth A. Grigg M.D. | | | 22b. DATE SIGNED 29 APRIL 1962 | | | |
| 22c. PHYSICIAN'S NAME (Type) KENNETH A GRIGG, Capt USAF MC | | | 22d. ADDRESS USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) SHIP | | 23b. DATE THEREOF 5-1-62 | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| 23d. LOCATION (City, town or county) PANAMA CITY FLA | | (State) | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co ADDRESS 517-17th St SE. | | | 25a. REC'D BY REGISTRAR MAY 3 '62 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kline | |

(M)

15001

05001

PERSONNEL

NAME

UNIT

ADDRESS

BOA

ADDRESS

US AIR FORCE

CONCORD AVENUE

ADRES

SAHARA

ADRES

MALE

CAUCASIAN

2 AUGUST 1948

ARMY

US AIR FORCE

UNITED STATES

YES

1941-1952

017-15-2522

ARMY

FRACURED SWELL AND INTERCERAMIC MEMORANDUM

ALLEGEDLY INVOLVED IN ALLEGATION

APR 12 02

NAVY

BALTIMORE

DOA

85

845

29 APRIL

29 APRIL

X

REPORT A CRIME, CAPT USAR, USAR HOSPITAL, ADDRESS AIR FORCE

BALTIMORE

15003

James I. Ford
4-1-1962
West Riverdale, N.Y.

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